

**Let's Face it: Video Conferencing Psychotherapy  
Requires the Extensive Use of Ostensive Cues**

Shimrit Fisher<sup>1</sup>

Timur Guralnik<sup>1</sup>

Peter Fonagy<sup>2</sup>

Sigal Zilcha-Mano<sup>1</sup>

<sup>1</sup> University of Haifa

<sup>2</sup> University College London

Author Note:

Shimrit Fisher, Department of Psychology, University of Haifa, Israel; Timur Guralnik, Department of Psychology, University of Haifa, Israel; Peter Fonagy, Research Department of Clinical, Educational and Health Psychology, University College London, London WC1E 7HB, United Kingdom; Sigal Zilcha-Mano, The Department of Psychology, University of Haifa, Israel.

Corresponding Author's Contact Information: Sigal Zilcha-Mano, Ph.D, Department of Psychology, University of Haifa, Mount Carmel, Haifa 31905, Israel, Telephone: 972-4-8249047, E-mail: [sigalzil@gmail.com](mailto:sigalzil@gmail.com)

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**Abstract**

The COVID-19 crisis has required many therapists to switch to video conferencing psychotherapy (VCP). Knowledge about the importance of epistemic trust and its determinants has been accumulating over the last few years, with important implications for psychotherapy and specific significance for the transition to VCP. The present paper provides a brief background on the concept of epistemic trust, research on the determinants of its development and the integrative framework it provides for some traditional concepts in psychotherapy, such as the therapeutic alliance. In particular, research on ostensive cuing, which requires significant modification in a remote delivery context, has important implications in the transition to VCP. We will advance some suggestions while illustrating the ideas with clinical case studies. This knowledge may be of value to psychotherapists, who are required to make substantial changes in the nature of the encounter with their patients, and may help them identify benefits and hindrances that might arise from this transition, as well as pointing out techniques that may encourage effective adaptation to the change.

Keywords: epistemic trust; video conferencing psychotherapy; COVID-19; Ostensive Cues

The present paper was written as the COVID-19 outbreak raged worldwide, forcing many healthcare professionals and their patients to shift to remote therapeutic encounters. This paper proposes guidelines for making the transition from face-to-face therapeutic sessions to videoconferencing psychotherapy (VCP). The proposed guidelines are based on the theoretical framework of epistemic trust (ET), which has important implications for the aims and conduct of psychotherapy (Fonagy et al., 2019). We argue that ET can be instrumental in facilitating the transition to VCP. Although many remote therapy platforms can be used, including emails, phone calls, on-line self-help modules, etc., (cf. Andersson et al., 2012; Johansson et al., 2012; King et al., 2014; Kingsley & Henning, 2015), the present paper focuses on VCP, a live synchronized conversation in which two parties can hear and see each other (Backhaus et al., 2012). The guidelines proposed in this paper for making the transition to VCP can be applied to any situation in which therapists and their patients are required to switch to remote sessions, as may be the case following relocation of one of the parties, injury that restricts movement or requires confinement in the home, meetings during long vacations, and more.

### **The establishment of epistemic trust**

Epistemic trust (ET) is defined as openness to acquiring social knowledge that is regarded as personally relevant and of generalizable significance (Bo et al., 2017; Fonagy & Allison, 2014; Luyten., et al 2019). When new (social) information is regarded as personally relevant, one might consider permanently accommodating it, thus changing or elaborating some information already stored. A general predisposition to ET is developed throughout social interactions, beginning early in life, including the infant's experiences with their primary caregivers. Infants are generally open to receiving social communications, especially from their primary caregivers, but are also biologically predisposed to be epistemically vigilant (Fonagy & Allison, 2014; Fonagy et al.,

2017). Epistemic vigilance refers to the ability to be justifiably suspicious about socially transmitted information, in a manner that helps protect one against potentially deceitful or erroneous information (Fonagy & Allison, 2014; Sperber et al., 2010). The ability to selectively prioritize vigilance or trust, depending on the circumstances, will allow individuals to flexibly adapt to the social environment in which they live (Fonagy et al., 2019). When faced with an ambiguous situation, infants appropriately seek an available adult. Depending on the adult's signals, the infant judges whether to approach the situation or to avoid it (Campos & Stenberg, 1981; Camras & Sachs, 1991). More recently, developmentalists identified signals such as eye contact, baby talk, turn-taking contingent discourse, calling an infant by name, and marked mirroring of the infant as cues often used by the adult to indicate that new, specific, and relevant information is being conveyed (Egyed et al., 2013; Gergely, 2013; Gergely & Cisbra, 2005; Gergely et al., 2007). It has been suggested that these signals, referred to as *ostensive cues*, play a key role in triggering a pedagogic (learning) stance in the infant (Gergely, 2013). Ostensive cues typically lead the recipient to feel recognized as a subject (Fonagy & Allison, 2014); therefore, they reinforce the recipients' capacity to benefit from positive influences in their environment and encourage faster knowledge acquisition (Luyten et al., 2020). Such positive signals increase the likelihood that the information delivered is accepted and generalized to other circumstances or interactions (Schröder-Pfeifer et al., 2018).

By contrast, when the infant's early environment is characterized by unreliable communications, the establishment of ET can become compromised. The individual's capacity to move flexibly between a stance of epistemic vigilance and ET is weakened. The consequences may be both an absence of appropriate openness to social learning or excessive credulity and inappropriate trust in unreliable informants. The compromised capacity to know when to trust and

whom to trust might significantly distort interpersonal functioning. For example, children with histories of adversity may become limited in their ability to update their knowledge and understanding of social situations, and appear inflexible or even rigid in the face of rapid social change (Fonagy et al., 2019).

### **ET determinants in development throughout life**

Children who have established a predisposition to ET, as opposed to those who have not, may demonstrate distinct developmental trajectories that may result in differing capacities to function in social and interpersonal contexts as adults. Those who successfully established ET as children are likely to be able to modify their inner position safely in the light of new information or experiences as adults (Fonagy et al., 2018). As adults, they tend to be curious about outside information and have a tendency to use interpersonal interactions as an opportunity for learning. Because they are open to learning about themselves and others, they can make sure that communication remains advantageous for them by maintaining appropriate degrees of vigilance (Sperber et al., 2010). In contrast, in the absence of ET, the capacity to change diminishes or becomes excessive (Fonagy et al., 2018); hence, individuals may find it difficult to downregulate their natural vigilance, meaning that they cannot accept valuable new information, or, at the opposite extreme, respond with epistemic credulity and believe and accommodate information from untrustworthy informants (Luyten et al., 2019).

In either case, the strategy is fixed and not malleable to the current context. Thus, new information is not retained in the person's knowledge structure; it is not generalized to other settings, even if it is temporarily accepted as true. This rigidity dictates that individuals rely on the same models of relating to the self and others, even in an environment that may be rapidly changing (Luyten et al., 2019). This perspective on the development of ET over the course of life eventually

creates a relatively stable behavioral pattern, which can be viewed as a trait-like characteristic of the individual. We have started to develop a framework for identifying high and low ET individuals, based on close textual study of their narratives in therapy. Table 1 (appendix) includes statements taken from actual therapies that may serve to illustrate all four categories of utterances.

### **Applications in psychotherapy**

Although the process of establishing ET originates in early social relationships, it is subjected to other influences throughout life (Luyten et al., 2020), including those of teachers, peers, and even social media. Psychotherapists may also nurture (or hinder) the further development of ET. According to this theoretical conceptualization, a meaningful outcome or therapeutic change is possible only if the patient can use the therapy in a positive way (Fonagy & Allison, 2014). To allow this to happen, the therapy must be sufficiently supportive and facilitate state-like improvements in ET over the course of treatment. Even more importantly in this context, ET is seen as a valid goal of therapy that may enable an individual to change their long-term attitudes towards others in their social network, and move their approach to relationships from one of epistemic mistrust and an incapacity to adapt, to one of trust, flexibility and an extended capacity to be influenced by a social network.

Given their distinct developmental trajectories, different patients may enter treatment with a distinct trait-like tendency to consider the information offered by the therapist as relevant to them, and to remember, retain and readily generalize it to other social contexts. Patients who demonstrate high trait-like ET are skilled in learning new and useful information about themselves. These individuals are willing to openly share their feelings, thoughts, and experiences with the therapist. They are curious and inclined to learn from therapy, assuming that the therapist's intentions are beneficent, or at least benign. The willingness to share and learn enables both the therapist and the

patient to seek, to understand, and to elaborate on one another's perspective, resulting in a strong alliance. Since implicit personal narratives may be more accessible for these individuals, therapeutic change becomes possible when the therapist recognizes and articulates their more nuanced self-experience, which emerges out of the primary content they share (Fonagy et al., 2019).

Some patients, however, begin therapy with low trait-like ET and may find it challenging to experience ET even when their personal narrative is appreciated (Fonagy et al, 2019). Their difficulty in reaching an agreement with their therapist stems from the fact that they distort the way others represent them, causing them to feel perpetually misunderstood and resulting in a poor alliance with the therapist. Interventions with epistemically mistrusting patients are, therefore, likely to be ineffective, unless the task of recognizing and jointly considering the subjective experience of the patient is achieved. Such recognition enables a shift in the direction of the general restoration of epistemic trust, which opens up the mind of the individual to benefitting from the routine sharing of social information within their social network; it encourages the patient to learn about themselves and others and update and adjust their knowledge structures, enabling improved functioning in the social world (Fonagy et al., 2019).

### **The transition to VCP**

Experienced therapists are somewhat undecided about the efficacy of videoconferencing psychotherapy (VCP) compared to face-to-face psychotherapy (Simpson & Reid, 2014; Vincent et al, 2017), but psychotherapy trials seem to show similar efficacy for both intervention modes (Backhaus et al., 2012; Norwood et al., 2018). Randomized control trials (RCTs) show that VCP is equally effective as face-to-face psychotherapy in terms of patient satisfaction (Backhaus et al., 2012; King et al., 2014; Kingsley & Henning, 2015; Simpson & Reid, 2014), therapeutic alliance

(Backhaus et al., 2012; Simpson & Reid, 2014), overall treatment outcome (Kingsley & Henning, 2015; Sucala et al., 2012), and improvement judged in terms of target symptoms (Backhaus et al., 2012). These promising effects of VCP have been found in the treatment of a variety of mental health disorders, such as depression (Backhaus et al., 2012; Berryhill et al., 2019; Chavooshi et al., 2016), anxiety and stress-related disorders (Backhaus et al., 2012; Chavooshi et al., 2016), pain and physical problems (Backhaus et al., 2012; Chavooshi et al., 2016), and addictions (Backhaus et al., 2012; King et al., 2014). It has been suggested that, with appropriate training and knowledge, practitioners with little experience in VCP can adapt their communication style and adjust to the technology (Simpson & Reid, 2014). The literature suggests guidelines for instructing practitioners through the transition to VCP, including ethical considerations and concrete issues related to the treatment settings and boundaries, for both traditional dynamic psychotherapy (Scharff, 2018), and protocol-based interventions (Backhaus et al., 2012; Chavooshi et al., 2016).

### **Distinguishing reaction to the transition to VCP by ET trait-like characteristics**

The literature on epistemic trust provides therapists with a theoretical framework to identify the patient's needs and to tailor the therapeutic techniques used in the treatment of such needs. Consistent with recent developments in psychotherapy research (Zilcha-Mano, 2018), a distinction between trait-like characteristics (individual differences between patients) and state-like changes (improvements occurring within the patient over the course of treatment) seems to be an important key in understanding how psychotherapy works, and how changes might occur in the wake of intervention (Zilcha-Mano, 2020). Drawing on our clinical experience and based on our work in the psychotherapy lab, we propose that the construct of ET can be considered as comprising these two distinct components. We have started to develop a framework for identifying high- and low-ET individuals, based on close textual study of their narratives in therapy. We found this process



surprisingly easy and are in the process of formalizing this distinction into a coding system which can be reliably used with therapeutic texts from a range of therapeutic modalities.

Transition to VCP requires a stance of willingness to change flexibly to adapt to a changed external reality, and a sense that such a transition is, or will be, of personal benefit, even if this is not entirely clear at first. Patients whose life trajectories brought them to mistrust social information conveyed by others are likely to mistrust the therapist as well. Bringing such a tendency to the transition from face-to-face therapy to VCP, these patients may question the true intentions of the therapist in inviting them to make such a transition together, and there is a risk that they may attribute malicious intentions to the therapist's invitation. For example, a patient might say: "You know it doesn't suit me, you know I can't meet in video and if that's the only choice, it means we can't meet at all. You don't want to meet me, do you? This is simply your way to bring this treatment to an end." Although these patients may agree to give it a try, they are likely to expect disappointment, much like their original feeling concerning face-to-face therapy. This may result in severe ruptures in the alliance (Safran et al., 2011; Safran & Muran, 1996, 2000), which may place the therapeutic relationship at risk and jeopardize the patient's ability to benefit from treatment, or even to remain in treatment. These patients may dismiss the therapist's efforts at reaching out, drop out of therapy, and question the future feasibility of therapy.

In contrast to patients with low trait-like ET, patients who show high trait-like ET find it is easier to make the transition to VCP. Over their life trajectory, these individuals have come to learn how to feel safe in the presence of a trustworthy person and may perceive the transition to VCP as an opportunity to learn about themselves and the way they function in a different social context. Transitioning from face-to-face therapy to VCP with openness to learn, they may find additional motivation to explore the medium, to find new methods that make it easier to share their

feelings, thoughts, and experiences with the therapist, and connect with the therapist so they are able to feel mirrored and understood, even if the two are divided by a screen. This may result in a renewed and strengthened alliance that reflects the shared journey of transition as a collaborative process that may enhance the patient's potential to make beneficial use of the therapy.

### **Guideline for an effective intervention**

Based on the ET literature and the various manifestations of high vs. low trait-like levels of ET, it is possible to derive a few tentative guidelines for making the transition to VCP. It has been suggested that ostensive cues are key indicators used in the context of a therapeutic process to revive or preserve ET (Fonagy et al., 2019). Ostensive cues signal to the patients that personally relevant information is being conveyed by the therapist. These may help them in the current context to adjust to the change to VCP. Below, we detail several suggestions of techniques for guiding therapists in the use of ostensive cues during transition to VCP.

1. Ostensive cues as physical signals. As the transition to VCP can be challenging for both therapist and patient, physical signals must be emphasized to support its effectiveness. Therapists can use physical ostensive cues in a variety of ways, based on different modalities: facial expressions like raising eyebrows or showing marked surprise; body gestures and mannerisms, like sitting straight and leaning forward; maintaining eye contact continuously; exaggerating voice intonation or making marked changes in tone; and being meticulous in turn-taking by waiting for the patient to finish speaking and pause before beginning to speak. An example from a therapy session demonstrates how such ostensive cues can be used. The patient and therapist had to transition to VCP because of the COVID-19 epidemic, after having worked face to face for several months. At the first VCP session, the patient was talking about a fight she had with her coworker, which was very frustrating for her. When

she described how “annoying” and inconsiderate her colleague was towards her, the therapist contracted his eyebrows (reflecting the patient’s possible anger or frustration), rolled his eyes, and groaned out loud (expressing the patients’ possible dissatisfaction). The patient then said: “Oh, I knew you would understand me! Isn’t it nerve-racking?”. Successfully projecting the feeling of being accurately mirrored and understood potentially sets the stage and prepares patients for learning new and useful information about themselves.

2. Ostensive cues as identifying the patients’ personal narrative. The patient's personal narrative is part of the construct of identity and is operationalized as a way of understanding oneself and others at a specific moment in time in relation to the world, in the past and the present (Fonagy et al., 2019). When the therapist recognizes and articulates the patients’ more nuanced self-experience, which emerges from the primary content, shared intentionality is achieved. Maintaining continuity in the patients’ personal narrative, bridging to something that was identified before the transition and articulated during the VCP session serves as an ostensive cue. Its articulation during a VCP session in the same way as it was articulated in face-to-face sessions emphasizes its personal relevance. Thus, the therapist may use bridging statements that deliberately make the connection between themes that were processed previously in the face-to-face encounter. For example, the therapist may use phrases like “It’s like we talked about a few weeks ago” or “This sounds to me quite similar to that incident you told me about when we met face-to-face.” This modality of ostensive cueing helps patients experience themselves as being understood contiguously across settings, making them inclined to learn from the therapist.
3. Ostensive cues as a direct reference to the change in setting. A variety of responses can be anticipated in the transition to VCP of patients with high vs. low trait-like ET, from an

inquisitive stance to a vigilant and more skeptical one. The therapists should be sensitive to the individual response of the patient and refer directly to the change in setting in a way that is tailored for the specific patient. The therapist may invite the patient to explore feelings, thoughts and perceptions that arise from the transition to VCP, and work through them in a way that fits the needs and characteristics of the given patient. Given that the transition is a dyadic change, rather than an individual process, exploring its meaning for oneself together with the therapist can help the patient feel protected by the shared reality, and the therapy can again be a safe and low-arousal environment (Fonagy et al., 2019). The therapist should use plural pronouns when articulating the shared experience, like “This is all very new for us” or “I was wondering how it would be for us to meet this way.” This technique may enhance the capacity of patients to regulate their affect through someone else, which is one of the building blocks of human self-organization (Fonagy & Target, 1997) and signals a restoration of ET. The objective is for the patient to apply the new regulation skills to other contexts.

### **Tailoring the intervention**

The techniques described above are important for patients with either high or low trait-like ET. Nevertheless, they should be prioritized somewhat differently according to the patient’s ET trait-like characteristics to achieve state-like changes. For patients with high trait-like ET, who tend to be easy to reach, the preferred ostensive cue is identifying their personal narrative. Their curiosity about the social environment and willingness to see the transition to VCP as an opportunity to elaborate their internal working model enables learning. One patient with high trait-like ET said at the beginning of the first VCP session, somewhat jokingly, “I guess this is a whole new way to see myself! And you know what? I look different than I expected. I kind of like this

new perspective.” Ostensive cues directly referencing the change in the setting work efficiently for such patients. They enjoy moments of mutuality with the therapist, feeling that they are safe together. Although physical ostensive cues are important in any human interaction, with patients with high trait-like ET, these are assumed to be less required.

Work with patients with high ET is demonstrated below, using a case study from an ongoing psychotherapy trial, in which patients diagnosed with Major Depressive Disorder receive 16 sessions of short-term psychodynamic treatment with either a supportive or an expressive focus. A detailed protocol of the trial appears elsewhere (Zilcha-Mano et al., 2018). The study was approved by the institutional ethics committee. The patients and therapists signed informed consent forms and agreed to be videotaped during the treatment. All background details are disguised to ensure the anonymity of the patients and therapists.

### **High ET case study**

Jordan is a 32-year-old undergraduate student. He sought therapy shortly after being expelled for failing to meet academic requirements. Three years earlier, the long-standing but conflictual romantic relationship he was in, had come to an end. Although a few years had passed since then, he found it difficult to get his life back on track and kept grieving over the loss of this relationship. Jordan blamed himself for mistreating his girlfriend, causing himself significant distress that resulted in depression and anxiety. Jordan was able to rapidly form a strong therapeutic alliance with his therapist. He shared his thoughts and feelings openly with the therapist, reflected inquisitively about himself and gained new insights. He tended to respond excitedly to statements from the therapist, when the latter articulated his latent narrative.

Demonstrating openness to learning new information, that is, to reviving ET early in therapy, indicated Jordan’s high trait-like characteristic. Jordan wanted to feel loved and desired, but most

of the time he felt unworthy. Because of a sense of being undeserving and fear of being abandoned or left alone, he had several superficial relationships with women, making sure that he was not alone at any given time. But he still felt lonely, alienated, and rejected. Four weeks into the therapy, the therapist recognized and articulated Jordan's central personal narrative: "It seems to me that it's so important for you to feel secure in a relationship, that you sometimes take all kinds of measures that are aimed at giving you some confidence, but don't allow the relationship to be deep or long-lasting. Eventually, you end up feeling the way you had tried to avoid: lonely and alienated". Jordan was wondering out loud: "I've never thought about it this way before (pauses). You know, when I think of it, I can see how this might explain many things in my life, especially in recent years."

After nine weeks in therapy, the COVID-19 outbreak and the ensuing curfews ruled out face-to-face meetings. The therapist offered to change over to VCP meetings. Jordan accepted without hesitation because he was keen on attending the therapy sessions. Given his high trait-like ET, the therapist prioritized the use of ostensive cues for identification of Jordan's personal narrative, as this was articulated before the transition to VCP, in addition to explicitly referring to the change in setting:

T: "Jordan, how are you, given all the restrictions?"

J: "Well...you know... I've had better times. I'm sitting here in my pajamas."

T: "Right, this is quite different from what we are used to." [Regarding the dyadic need to adjust together].

J: "Yeah, I guess. But it's not bad, it has its advantages. After all, I can't complain, sitting here in the comfort of my home."

T: "There is no place like home, is there?"

J: “Absolutely, you got that right.”

T: “Well, I’m very happy we can still meet despite these challenging times for us.” [the therapist provides an ostensive cue regarding the dyadic need to adjust together].

J: “So do I. Yeah (sigh). I’m a bit confused... I’m not sure what to talk about.”

T: “Last week you told me about that new girl you met.” [therapist helps with continuity].

J: “Right! So, I met this girl, and I felt it’s going to be different this time. Now... I’m not sure it’s going to last. Anyway, it’s probably dead. So maybe I’ll call that girl from the bar, do you remember her?” [personal narrative emerges from the main content].

T: “Certainly.”

J: “Say, do you think we can keep having our regular meetings even though we can’t meet in person?” [manifestation of a state-like ET change, as the possible application of his somewhat renewed internal working model against feeling lonely].

T: “This is of great importance for you, isn’t it?”

J: “Yeah...It’s like we are always saying – staying alone doesn’t bring me closer to what I wish for [ability to refer to the therapeutic continuity and its collaborative aspects, and to retain themes that were previously processed].

T: “Right, Jordan. You’re able to identify it while it’s happening to you in real time!” [reinforcing the application of relevant information]. “I see what you’re saying. Is it similar to what happened with your ex-girlfriend? Maybe fear is taking over again?”

J: “Oh, let’s see. It might be (sighs). But what else can I do? How can I protect myself?”

This short vignette illustrates how Jordan’s high trait-like ET influences the therapist’s decisions about the techniques to be used during the transition to VCP, and how to choose the ostensive cues that are needed to reinforce state-like ET changes. His current crisis makes Jordan

feel that he should be somewhat vigilant about others' intentions toward him, and he believes his new romantic relationship is going to end before it has properly begun. When he was working through the underlying narrative in face-to-face mode, Jordan appeared fearful about the possibility of being abandoned, and he took some steps to make sure this would not happen to him. Signaling to Jordan that his subjective experience has been recognized, encourages him to reply with further elaboration. Jordan shows interest in what the therapist has to say because he can recognize it as personally relevant to him. This promotes better understanding about the best way to navigate the social environment in the face of upcoming challenges (expecting the therapist to keep seeing him). This tendency reflects the restoration of ET in a challenging context: Jordan is willing to see the therapist as trustworthy and willing to try out different kinds of behaviors outside the therapy room. This means that state-like ET changes in the course of therapy revive trait-like ability to learn and adapt to our ever-changing environment.

### **Low ET case study**

In contrast to patients with high trait-like ET, patients with low trait-like ET may be highly alert to small nuances in the therapist's reactions in the transition to VCP because of the past difficulties of these patients in trusting socially transmitted information. All too readily, hypervigilance may be activated, and the therapy is liable to deteriorate. To handle this situation effectively, therapists should convey to their patients that they understand their current narrative and validate their present subjective experience, even if this is divergent from that of the therapist and arguably 'false' in relation to 'objective' reality. Recognizing the patient as an agent, even with expectations and constructions wildly different from the therapist's own, has the potential to revive ET and make it more likely that learning from the therapist will be ultimately possible.



With these patients, the technique that prioritizes physical signaling and the simplest ostensive cues is most likely to be helpful. Therapists may consciously and deliberately make extended use of marked facial expressions, contingent turn-taking reactivity, marked mirroring, and continuous eye contact. This physical emphasis can help, to some degree, to allay the patient's vigilant stance. Validation of the patient's experience, paraphrasing to indicate understanding and only gently going on to ask for elaboration and expansion of statements made by the patient is necessary to (re-)establish trust after a shift to VCP. Therapists should use physical ostensive cues to help their patients feel they are not alone, and, despite their natural hypervigilance, to be able to benefit from the possibility of a collaborative relationship with the therapist to make a successful transition to VCP.

Ostensive cues directly referencing the change in physical setting might be effective, as it is the physical aspect of the therapeutic environment that is most likely to be felt as shared by the patient. It is essential to empathically validate their declared experience, whether their feelings are positive or negative in nature. Considering the transition to VCP uniquely from the patient's point of view can eventually help revive ET to move beyond the change in physical environment and make learning from therapy once again possible. Attempts on the part of the therapist at re-presenting to the patient an overly detailed version of their personal narrative are unlikely to be helpful, as the patient (a) will likely fail to identify clearly the therapist's representation of their personal narrative and (b) even if they do, the distortions in both their representation of what they believe the therapist sees, and in their own self-image are likely to be so great that an epistemic match is not possible to achieve. Thus, elaborating the patient's personal narrative may be less effective in helping these patients adjust to the transition to VCP. Because the transition has the potential to trigger enhanced vigilance, even an accurate articulation of one's personal narrative

might be experienced as inaccurate by the patient, causing a painful experience of interpersonal alienation to persist. A case study from the ongoing psychotherapy trial mentioned earlier (Zilcha-Mano et al., 2018) is used below to demonstrate work with patients with low ET.

Nicole, a 19-year-old student, sought therapy after several months of experiencing mild depressive symptoms. When she was 12, her father died of a sudden cardiac arrest, and she had to take care of her younger sister and her mother, who suffered from recurrent and persistent depressive episodes after losing her husband. After graduating from high school with honors, she enrolled in an academic excellence program for young engineers, and trained to integrate into the high-tech industry. Her choice was motivated by the desire for a good professional future and a steady income at an early age. Nicole began her studies with enthusiasm, but quickly became discouraged. She struggled with the highly intense curriculum, and tuition fees imposed a great financial burden. Moreover, because of her relatively young age, she had difficulty socializing with other students. At the first therapy session, she described harsh feelings of anger toward her high school teachers, who had recommended that course of study. She was also jealous of her friends, who enjoyed the support of their parents and were free to enjoy leisure activities.

Altogether, she had recently become impatient with people around her, and tended to erupt whenever she felt injustice being done. Nicole had never been in therapy before, and at the first session, she stated: "I highly doubt you can help me. This is the reality; you can't change it. Will you make my studies easier? Will I have more money in the bank? Will my father come back into my life? No. So maybe it's a waste of time. Any way, you can't understand." After several meetings, her internal narrative became clear. Nicole wanted others to validate the injustice done to her in life and become witnesses to it. She wanted them to be able to see and understand what makes her so angry and to justify her. Although she wanted them to understand, this wish

conflicted with her difficulty in honestly sharing her feelings and thoughts with them. She seemed to fear that, if she shared her feelings, she would be criticized and judged, and as a result, she avoided it. When sensing injustice, she became angry and flew into a rage. After each outburst, however, she felt guilty and self-critical, and regretted her rude behavior. As the weeks passed, Nicole attended the sessions but showed resistance to change. Although she had occasionally been able to feel understood and began to contemplate the possibility of restructuring her life story in response to other perspectives, she was not able to apply new insights outside the therapy room. It was clear, however, that the social reality was changing and that the COVID-19 outbreak required transitioning to the VCP. Therefore, an opportunity was created within the protected framework of therapy to experience the significance of learning new information from the therapist. After coordinating the change in the therapeutic setting, from session 8 onward, therapy carried on through the VCP mode. Given Nicole's low trait-like ET, the therapist prioritized the use of physical ostensive cues, in addition to explicitly referring to the change of setting.

N: "Well, well. How did you manage to coax me into such a session? It's unbelievable! Do you really think it's worth something?" [Nicole exhibits low trait-like ET, as manifested in her doubtful attitude toward VCP].

T: [Smiling and moving closer to the camera to send a physical ostensive cue]. "Yes, this change is really tough!" [Validating]. "I'm very impressed, you know. Even though you said video conversation is not your cup of tea, you agreed to give it a try." [Reinforces the potential of a learning experience]. "How are you doing, Nicole?" [Addressing by name].

N: "I'm fine. Now that everyone around me is anxious and depressed about the situation, I'm no longer exceptional. Say, what are you doing there?" [Refers to the therapist moving her gaze downward].

T: [Opens eyes wide, raises eyebrows in wonder] "You're sharp! you don't miss a thing! Well, I looked down to move my mic closer. I wasn't sure it was placed correctly. What did you think I was doing?" [First validating her reality testing, then indirectly inviting a joint investigation of the vigilance around the nature of the meeting].

N: "To tell you the truth, I thought you could now do a million other things and pretend to be listening to me, and I'd never know. I'll be talking like an idiot, and you'll nod while answering your emails."

T: "I see. You're absolutely right; you can't be sure what I'm doing behind the screen. That probably feels awful!" [Empathic validation with contingent facial expression and a bit exaggerated intonation, keeping constant eye contact].

N: "It's awful indeed."

T: "It's really important for you to feel that I'm 100% with you. When we met at the clinic last week, you told me video calls were not your cup of tea". [Maintaining continuity between face-to-face and VCP contexts and use of the patient's language as ostensive cues]. "But Nicole, maybe now that we're here, you can share with me a little bit how it is for you?" [Inviting a joint exploration of feeling, and making the connection to the pre-transition sequence].

N: "It makes me feel you're not bearing with me here, and it makes me a bit angry."

T: "Angry? I'm curious." [Contracting eyebrows, slightly nodding to communicate interest in her subjective feeling].

N: Look, all this Corona Virus thing is weighing down on me. I can't learn, can't work, can't work out. It's not fair. It's a lot to take. This session is another challenge I must face now,

you know, it's not that easy to find a quiet place in my house [A possible narrative emerges, but the therapist must be careful not to relate to it at this point].

T: "All these changes demand a great deal from you. It doesn't sound simple at all. There are always tasks you are required to do, and a video call with me is one of them, right? [The therapist is being supportive, and shares her best understanding to make Nicole feel she is with her].

N: "True, another task to manage, and I'm not even sure it's worthwhile. I'm so overloaded that every little thing burdens me. At least you can understand it, it's more than my mom and sister are able to do." [Conveying the feeling of being understood can be achieved because of prior extensive use of ostensive cues].

T: "It's very impressive that you have not given up trying. And here we are, together. For a moment it may also feel that it's not so bad." [Reinforcing parts of effective coping].

N: "I admit it's a little encouraging to see you smile at me like that. And it does feel good to share my feeling without being judged."

T: "Recently, you've been trying all kinds of new things." [Reinforcing the learning process].

N: "Totally. At least I try. Maybe seeing you every week will be worth something, in the end."

T: "that's a different way of seeing things compared to the way you started therapy."

Nicole's case illustrates how patients with low trait-like ET enter the transition to VCP in a state of hypervigilance, conducting themselves in similar ways to other situations in their lives. For Nicole, and other patients like her, with low trait-like ET, to be able to successfully make this transition and continue the therapeutic work, the therapist is required to use more distinct and clear ostensive cues.

Although the covert narrative may emerge from the main content, any reference to it during the transition phase might cause patients to feel that their subjective experience is being dismissed. Rather, extensive ostensive physical cues, such as marked facial expressions, contingent reactivity, maintaining constant eye contact, etc., can help patients with low trait-like ET recognize the therapist as trustworthy. This, in turn, enables the revival of ET and makes it possible for state-like changes to occur. Trusting what the therapist has to offer in the course of psychotherapy stimulates curiosity and enables the patient to continue acquiring social information that is personally relevant for coping. After Nicole's internal working model has been elaborated within the therapeutic context, there is a good chance that she might try to further apply it outside the therapy room.

### **Discussion and Conclusions**

The present paper was written while the COVID-19 pandemic imposed a substantial change in the way psychotherapy was delivered. The proposed suggestions, however, are most likely applicable to any situation in which it is necessary to switch to a remote mode of therapy. The guidelines suggested here may contribute to steps therapists follow to tailor the transition to VCP to their patients' trait-like ET characteristics, which can help therapists navigate the transition and choose the techniques that are expected to be most effective.

The techniques are based on a set of guidelines for the use of ostensive cues (a) as physical signals, (b) for identifying the patients' personal narrative, and (c) as a direct reference to the change in setting. These techniques may enable therapists and patients to achieve the desired state-like ET improvements. However, the State-like vs Trait-like distinction and its adaptation to the context of epistemic trust is very preliminary. Further in-depth research needs to be carried out to validate this distinction and to strengthen its application in the therapeutic context.

The primary focus of the present paper was the transition to VCP for an ongoing course of treatment. There are cases, however, in which psychotherapy is initially conducted through VCP, prior to establishing the therapeutic alliance and without the opportunity to assess a patient's ET in advance. Nevertheless, similar considerations should be taken into account in commencing therapy. In such cases, the therapist should prefer to use physical ostensive cues, such as eye contact, marked facial expressions, etc. These cues are a basic point of reference that can be effective for any patient and has no harmful potential for the therapeutic relationship.

The present paper focuses on adult therapy, but can also be adapted to guide therapists in the transition to VCP with children. Because children rely heavily on physical ostensive cues from the adults around them, it is important to consider using such cues first and foremost. In psychotherapy with children, these cues can be used playfully and in an exaggerated manner to signal to children that their subjective experience has been identified by the therapist. For example, children are sometimes expected to relate to the change in setting through a hide-and-seek game, to help them process the breakup and reconnection experience. Although they are in different rooms, wondering aloud about the child's whereabouts when hiding, searching for the child in the room, and showing excitement when the child is discovered are important signals that may support a sense of agency.

The present paper focuses on psychodynamic therapy, but the proposed suggestions can also be relevant to making the transition to VCP in other therapeutic orientations. Because they contribute to the therapeutic alliance, these guidelines are not unique to a given therapeutic approach. It has been suggested that the therapeutic alliance is not merely a product of successful treatment or the context in which successful treatment is provided, but rather it can serve as an active ingredient in itself, relevant to all types of therapies (Zilcha-Mano, 2017). Cognitive behavioral therapy, for example, can use homework given before switching to VCP as a way of

maintaining continuity in the patient's narrative. In other protocol-based therapeutic approaches, continuity is maintained by being more meticulous about treatment goals at each meeting.

As the guidelines suggested here are being applied to the COVID-19 situation, as with any other global or local disaster, it is important to take into account the mental health effects of the situation on both the patient and the therapist. Under a shared traumatic reality (Boulanger, 2013), both therapist and patient are exposed to the same public risk factor. When both sides are at similar risk, a strong symmetry may be created between their experiences in adversity. To continue to support patients in a positive way and to contain feelings of anger, rejection, need, or anxiety, therapists must find sources of support and resilience for themselves, otherwise they may overidentify with their patient and possibly fail to recognize the patient's distress signals.

In the ever-changing reality of our lives, as the world is increasingly moving online, it seems important to preserve the characteristics of human communication as we know them from face-to-face encounters, and embrace them as we are going online. Under such circumstances, ET can provide healthcare professionals a tentative framework to meet this challenge. Being able to address the dialectic of remote care that meets human proximity needs is an important challenge, and how therapists meet it, may determine the continued relevance of the field in the face of global change.



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**Appendix**

We have started to develop a framework for identifying high- and low-ET individuals. We start by distinguishing momentary experiences of epistemic vigilance, which we consider normative low state-like ET. Other individuals make statements that imply longstanding mistrust and hypervigilance, which we would regard as indicators of having low trait-like ET. Both low and high trait-like ET individuals will manifest instances of low state-like ET, as evidenced by statements that apply to specific situations within delimited settings. It is our expectation that low trait-like ET individuals will evidence a greater number of low state-like ET statements and fewer high state-like ET statements than high trait-like ET individuals. As an illustration, Table 1 includes statements taken from actual therapies that may serve to illustrate all four categories of utterances.

Table 1. Examples of the ET markers sorted by the two categories of state-like vs trait-like.

<b>State</b>		<b>Trait</b>	
High	Low	High	Low
"I gradually shared more, and I said to myself - well this is a really good opportunity to stop	"I tried to talk with my husband, but I could tell right away that he is not interested in listening to me.";	"I felt that sharing was inevitable in some way, because that's how I grew up and that's how I got used to it.";	"I don't think I have anyone in my life that I feel comfortable enough to really share openly with.";

pretending and start

telling and sharing.";

"At the beginning I thought it's all fine. But after talking to the other student I felt a little uncertain. I started to think that maybe it's not all fine, maybe there is a bigger problem that I miss out here."	"I talked to him about that and he immediately made all kind of suggestions. But it was all rubbish! All those solutions didn't help, it only made things worse."	"I am trying to think about it... after talking to my wife I always ask myself if there is anything new that I didn't think of before."	"This is wrong. I can't relate to anything that you are saying, and I will not consider it. This thing is of great importance to my family, it has always been. I won't change the way I see it."
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