

# **Epistemic Trust and Mentalizing in Adolescent Therapeutic Alliances**

Georgina M. Aisbitt

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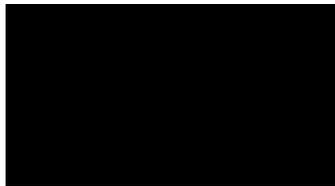
University College London

**UCL Doctorate in Clinical Psychology**

**Thesis declaration form**

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:



Name: Georgina Aisbitt

Date: 11<sup>th</sup> June 2020

## Overview

This thesis explores the role of epistemic trust in adolescent therapeutic alliances. The literature review in Chapter 1 draws together research in these areas with related concepts of attachment, mentalizing and social network engagement. This encompassing framework is used to understand presentations characterised by difficulties in these domains, including borderline personality disorder and psychopathy. Hypotheses are formed regarding reasons for difficulty engaging in a therapeutic alliance and avenues for future research are outlined.

The empirical study in Chapter 2 carries forward some of these hypotheses to test, using a novel approach to understand therapeutic alliance judgments in adolescents currently engaging in therapy. These judgments are studied in relation to epistemic trust and mentalizing and contrasted with clinician ratings of the alliance. This is considered in the context of broader patterns of structural and functional social network support. The scope and analysis of the study was revised following data-collection restrictions due to the COVID-19 lockdown. Hence, the empirical paper offers only preliminary evidence of associations between broad study concepts. Most notably epistemic trust related to client presumed clinician alliance judgments, suggesting that some clients may not view clinicians as trustworthy. The findings require greater exploration and replication in larger samples.

The critical reflection in Chapter 3 explores some of the future research potential, as well as challenges encountered in the research process. Space is given to consideration of the importance of engagement and cultivating trust in the current global context and with future service development in mind.

## **Impact Statement**

As many as ten percent of children and young people in the UK have a diagnosable mental health problem. Many of these will show little or no progress in therapy and many more will never access therapy at all. Understanding factors that contribute to these barriers to successfully engaging in treatment is crucial to changing service delivery and altering the lifetime health trajectory of these young people. This thesis provides a review and empirical exploration of one factor theorised to play an important role in therapeutic engagement: namely epistemic trust, an openness to learning from others.

Epistemic trust, therapeutic alliance and the related concepts of attachment, mentalizing and interpersonal relations are brought together theoretically in Chapter 1 and empirically in Chapter 2. In doing so the existing knowledge base is consolidated and built on, allowing greater perspective on factors that may be impacting the therapeutic alliance. Moreover, consideration is given to why certain young people's engagement is particularly affected, helping us understand variations in treatment engagement. Gaps in the literature are identified and promising directions for subsequent studies to address this are outlined.

A novel method for exploring client views of the therapeutic alliance is used to help to differentiate what the client thinks of the clinician and what they believe the clinician thinks of them. This offers an opportunity to better understand how the client views the alliance. Future research is warranted using growth change models to explore how these factors may develop naturally in the course of therapy, and ultimately how they may be altered through direct intervention.

Clinically, this research helps increase awareness of the role of epistemic trust in establishing the therapeutic alliance. This is important for a clinician in terms of awareness of possible barriers to engaging with a client and facilitating change in these. The research highlights individual differences in responsiveness to the alliance and the critical reflection in Chapter 3 opens up the idea that this will need

to be accommodated for in therapy, for instance by giving additional time or space to alliance formation and discussion. This in turn is important at a service-level when considering the delivery of treatment and how it can best meet the needs of the clients. The literature reviewed stresses the importance of engaging a client in a therapeutic alliance and how the client's perception of the alliance predicts treatment outcomes. By better understanding factors contributing to the client's alliance judgments, we may indirectly be able to positively influence outcomes by altering adolescent's relationship to help.

The research in this project is continuing, with a view to pursuing dissemination through publication in a scholarly journal. The research will also be fed-back to the services who participated in the project, and presented to an NHS adolescent inpatient unit.

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## **Part 1: Literature Review**

**Hearing is (not) believing: How epistemic trust and mentalizing impact  
therapeutic relationships in adolescents**

## **Abstract**

“You must trust and believe in people, or life becomes impossible.”

Anton Chekhov

Many adolescents find engaging in therapy difficult, leading them to be labelled as ‘hard to reach’. This review explores whether factors from early development may help explain these patterns of (dis)engagement and considers whether these adolescents are indeed hard to reach, or if it is hard for us to reach them. Focus is given to the potential role of epistemic trust, that is trust in the communication of others. The developmental aetiology of epistemic trust is reviewed alongside the related concepts of attachment and mentalizing. The disruptive effect of childhood trauma on these developmental functions is considered and used to understand the longer-term impact of adverse early experiences. The bearing of these factors on interpersonal relationships is discussed and used to develop a hypothesis for understanding challenges in therapeutic engagement. This framework is applied to borderline personality disorder and psychopathy to see if disruptions in epistemic trust and related concepts may help explain why therapeutic engagement appears particularly challenging in these groups. Limitations of the existing research are discussed and hypotheses to drive future research are outlined. In better understanding how trust in the therapeutic alliance may be disrupted before therapy even begins, we can seek means to repair this and support young people to engage.

## **Epistemic Trust**

Trust is a cornerstone of human social communication and learning. It provides a foundation for the rapid transmission of socially and culturally relevant information that may otherwise be too time-consuming or risky to garner through episodic experience alone. Csibra and Gergely (2009) called this 'natural pedagogy'. They argue that humans are uniquely adapted to share and receive generic knowledge that is communicated linguistically or manually. This information can be internalised for future use and generalised to new contexts or situations, thereby allowing for efficient development of shared knowledge between people and generations.

However, in order to protect oneself from misinformation, there has evolved a natural sense of caution around the accuracy and relevance of information that is communicated (Csibra & Gergely, 2009; Mascaro & Sperber, 2009). This state of 'epistemic vigilance' is understandable given the potential detriment of internalising and generalising inaccurate social and cultural information. Therefore, in order for new information to be assimilated the protective suspicion of epistemic vigilance must be temporarily suspended, and a state of epistemic trust must be cultivated. This triggers the opening of an 'epistemic superhighway' and evokes a state of readiness to acquire knowledge (Fonagy & Allison, 2014).

This epistemic trust is believed to be facilitated by the use of ostensive cues, which prime the individual for the communication. These cues signal both an intent to communicate important information ('communicative function') and that the information is intended specifically for the individual ('addressing function'; Fonagy, Gergely, & Target, 2007). For example, the communicator may look someone in the eye and use their name to direct attention to the communication. These ostensive cues are particularly important in infants, who Csibra and Gergely (2009) argue are 'primed' to receive such communications. They cite evidence from studies of infant learning in support of this (see: Carpenter, Call, & Tomasello, 2005; Southgate,

Chevallier, & Csibra, 2009), highlighting differences in toddler learning, depending on whether certain information was flagged as important or not by the demonstrator. What's more, given sensitivity to ostensive cues is of central importance to communication, Csibra and Gergely argue that at least some of this sensitivity is likely to be innate. They discuss supporting evidence from studies showing newborn infants' preference for looking at faces with directed gazes as opposed to averted gazes, with the former seen as more indicative of communication (Farroni et al., 2002).

### ***Epistemic Trust and Attachment***

But, not all information or all adults are trusted equally (Harris & Corriveau, 2011). Fonagy and colleagues (Fonagy et al., 2007; Fonagy & Allison, 2014) have suggested that the development of this epistemic trust is tied to attachment security, and that the two processes share a common predictor: ostensive cuing. A sensitive caregiver will offer consistent emotional responses to an infants' needs and will use ostensive cuing to assist in this: making eye-contact, using an appropriate tone of voice and demonstrating contingent reactivity. This means that the reliable emotional responsiveness that characterises secure attachments is communicated through the same ostensive cues used to cultivate epistemic trust and a readiness to learn in the infant. Therefore, ostensive cues may enable an infant to develop an expectation of not only physical security but also informational security from their caregiver. The evolutionary advantage of this is clear: the infant can rapidly acquire important information from a trusted source, without the need for further scrutiny (Fonagy et al., 2007).

This relationship between attachment and epistemic trust was explicitly tested, and demonstrated, by Corriveau et al. (2009). In the study, 147 children were tested at 50 months and again at 61 months for their ability to name pictures of novel hybrid animals and objects. The images were made up of either a 50-50 or 75-25 hybrid ratio, for instance of a horse and a cow, or a pen and a brush. The children

were given the opportunity to ask their mother or a stranger for guidance or were given conflicting information by their mother and the stranger as to what the animal was. In the 75-25 conditions the mother always endorsed the less likely 25% portion of the hybrid. For example, a 75-25 horse-cow hybrid would see the stranger endorse this as a horse and the mother endorse this as a cow. Children were assessed on who they chose to ask for guidance and which person's information they subsequently endorsed. The results showed that overall: in the 50-50 condition, children are more likely to ask for and endorse their mother's opinion compared to a strangers'; however, in the 75-25 condition children favoured the stranger's opinion which was more consistent with the appearance of the object.

Crucially, this pattern also varied with attachment style. Securely attached children showed a flexible and adaptive pattern of trust and reliance on the mother, depending on the how consistent their claim was with the available evidence. In contrast, ambivalently attached children showed much greater reliance on the mother, even in the face of conflicting information, and avoidantly attached children showed relatively little reliance on the mother in any condition. This demonstrates how attachment style relates to the flexible use of epistemic trust to critique and assimilate shared information. It also suggests that secure attachment relationships may be key for the development and application of epistemic trust. This may account for the cognitive advantage found in individuals with a secure attachment style (e.g. Crandell & Hobson, 1999; Moss, Rousseau, Parent, St-Laurent, & Saintonge, 1998) as a securely attached infant will be more likely to open their epistemic superhighway and in so doing benefit from complex social knowledge that is held in a culture and passed down by social elders (Fonagy et al., 2015).

What is not clear is the extent to which this relationship between attachment and epistemic trust merely reflects their shared dependence on the use of ostensive cues. Put simply, does this really show a driving relationship between attachment and epistemic trust, or rather that both are dependent on a third variable, which

results in their correlating? Further research would need to incorporate direct measures of the use of ostensive cues in order to better understand this relationship and to more clearly infer causality.

### ***Epistemic Trust and Mentalization***

The cultivation of epistemic trust is interwoven with the development of mentalization and the experience of being mentalized (Fonagy et al., 2007, 2015; Fonagy & Allison, 2014). Described as a form of social cognition (Fonagy & Luyten, 2009), mentalizing is the ability to understand our own and others' behaviours to be purposeful and goal driven. It allows us to ascribe intention to action, interpreting actions in the context of emotional states. Mentalizing is multi-dimensional and varies along four polarities: automatic vs. controlled mentalization; use of internal or external sources of information; cognitive vs. affective mentalization; and, mentalization of the self or others (Fonagy & Luyten, 2009). Mentalizing is most effective when these polarities are in balance, and when they can be used flexibly depending on the context and available information. Level of emotional arousal also influences mentalizing quality. In a state of high emotional arousal an individual who is normally able to mentalize themselves and others relatively well may struggle and rely more heavily on affective or automatic mentalization. What's more, if the cause of their high emotional arousal relates to the individual whom they are trying to mentalize, the process will be even more affected. This demonstrates the 'state' and 'trait' characteristics of mentalizing.

Like other forms of communication, mentalizing is interactive: not only does it develop in the context of relationships with other people, but our own mentalizing capacity continues to be influenced by the mentalizing capacity of those around us (Fonagy & Allison, 2012; Fonagy & Luyten, 2018a). As with epistemic trust, mentalizing abilities develop in relation to early experiences and attachment relationships (Fonagy & Allison, 2012). This begins with the caregiver's capacity to mentalize, with better mentalizing predicting a more secure attachment style in the

child (Fonagy et al., 1991). In turn, relationships characterised by secure attachment garner a safe curiosity in the child to explore their own mind and the minds of others (Fonagy & Luyten, 2009). With this the child learns to differentiate themselves psychologically from others and so acquires a sense of agency and their own ability to mentalize (Fonagy & Luyten, 2018a). In other words, a caregiver who can mentalize facilitates development of the same ability in the child.

It follows that the on-going context of relationships influences the ability to interpret the intention behind ones' own and others' actions. For instance, if a child is in a state of high arousal where mentalizing is jeopardised, sensitive responding from their caregiver will help down-regulate the emotion and return them to a state where they can mentalize. Conversely, if the caregiver is also in a state of high arousal in which they fail to mentalize the child, then the child will likely feel high arousal, a loss of the experience of being mentalized and a disruption to their ability to mentalize others. This loss of mentalizing is hugely determinantal due to its adverse effects on social collaboration and adaptation to the environment (Fonagy et al., 2007).

Given the proposed commonality of the developmental link with attachment relationships, it seems reasonable that both epistemic trust and mentalizing are underpinned by the use of ostensive cues. The role of ostensive cues in relaxing epistemic vigilance and cultivating epistemic trust has already been discussed. Cues such as contingent responding and marked mirroring also enable a child to learn to mentalize by forming and internalising a second-order representation of the attachment figure's representation of themselves (Bo et al., 2017). Overtime, this allows for a sense of self and a sense of other to be developed. This relationship between ostensive cues and development of mentalizing is consistent with ostensive cues activating neural networks responsible for mentalizing (Kampe et al., 2003). Kampe and colleagues explored neural circuitry activation patterns to two ostensive cues (eye-contact and use of the subject's name) as compared to other

related but non-communicative cues (no eye-contact and use of a different name). Using fMRI in sixteen adults, they found that circuits involved in the process of mentalizing were selectively activated for the ostensive cues, as compared to the non-communicative cues. Kampe and colleagues suggest that the ostensive cues facilitated mentalizing by helping individuals to ascertain the intent behind a communication. Asking yourself 'are they talking to me?' is more easily answered if the person is looking you in the eye and using your name. As such, it appears possible to use ostensive cues to help you mentalize the other person: assigning (communicative) intent to their behaviour.

Indeed, mentalizing itself can act as an ostensive cue to facilitate the development of epistemic trust (Fonagy et al., 2015). If communication is 'marked' by recognition of the infant as an intentional agent, this feeling of being mentalized increases the chance of communication being considered relevant to the self. This relaxes epistemic vigilance and cultivates epistemic trust. On the other hand, if the infant is not appropriately mentalized not only will they will not develop their own mentalizing capacity, but they will maintain a state of epistemic vigilance. Therefore, the processes of mentalizing and epistemic trust appear interwoven.

### **Epistemic Mistrust**

Despite its importance, the development of epistemic trust is far from a foregone conclusion and the process by which it develops can be derailed or moderated by some (unfortunately) common occurrences: including disrupted attachment and trauma (Lane & Harris, 2015; Mascaro & Sperber, 2009; Sharp, Pane, et al., 2011). As discussed, a degree of vigilance and sensitivity to sources of information that are unreliable or malevolent is adaptive and can be seen across children from as early as 3 years-old (Mascaro & Sperber, 2009). Children show more trust towards those that have provided reliable care and information in the past, providing an adaptive heuristic for favouring information from familiar caregivers and conversely being less trusting towards those who are considered

unreliable (Harris & Corriveau, 2011). However, if this epistemic vigilance is overdeveloped or becomes overgeneralised it can cause difficulty, the nature and impact of which we are only beginning to understand.

In instances of maltreatment or trauma, there may develop a state of epistemic mistrust, characterised by persistent scepticism of the authenticity of the communicator and the information they communicate (Fonagy, Luyten, et al., 2017a). In circumstances where a child is subject to maltreatment, their caregiver may misuse ostensive cues to transmit destructive knowledge (Fonagy et al., 2015). Children may come to recognise these communications of care or information as unreliable or mal-intentioned, and thus learn to generally reject them. This state of epistemic mistrust is adaptative and protective as it will shield the child from internalising harmful misinformation. However, it comes at a cost: the child is more generally closed-off to communication of social information and the capacity to mentalize. This absence of social learning may represent what McCrory and colleagues described as one of the 'latent vulnerabilities' associated with childhood abuse: an alteration to neurocognitive functioning that is adaptive in the adverse early environment, but which confers long-term risks to functioning (McCrory et al., 2017).

Epistemic mistrust can take different forms. At a broad level it can be thought of as the unbalancing of the natural tension between communication for learning and protection of self. As well as the link between secure attachment and epistemic trust, Fonagy and Allison (2014) outlined how other attachment styles link to particular patterns of epistemic (mis)trust. Ambivalent and avoidant attachment styles are both characterised by a lack of confidence in one's subjective experience, although the former relates to over-reliance on the attachment figure and the latter to under-reliance on the attachment figure. These patterns are consistent with the evidence reviewed from Corriveau and colleagues' study of infant trust in mothers and strangers, with ambivalently attached children favouring the mother, even when

her claims were improbable, and the avoidantly attached children withholding trust from their mother and favouring a stranger (Corriveau et al., 2009).

More extreme levels of epistemic mistrust are termed 'epistemic freezing', or 'epistemic hypervigilance' and are associated with a disorganised attachment style (Fonagy & Allison, 2014). This pattern of relating is characterised by mistrust of all information, whether communicated by a caregiver or stranger, or even information garnered from one's own experience (Corriveau et al., 2009). It is often linked to a failure to appropriately mentalize, or more specifically, a tendency to hypermentalize: the ascribing of intentions or goals to people and communications where none exists (Fonagy et al., 2015). This can result in the misattribution of malintent to the communication of information from any source. As a result, the individual is left isolated and uncertain, endlessly seeking validation and unable to trust even their own experience.

### ***Epistemic Mistrust and Borderline Personality Disorder***

It is suggested that this pattern of epistemic hypervigilance and hypermentalizing characterises borderline personality disorder (BPD; Fonagy, Target, Gergely, Allen, & Bateman, 2003; Sharp & Venta, 2012). BPD is defined by emotional dysregulation, impulsivity and severe and persistent impairments in interpersonal functioning (Hill et al., 2008). BPD has only recently been accepted as a valid and reliable diagnosis in adolescents (Bo et al., 2017) and this has heralded a focus on the developmental understanding of the disorder and the role of frightening or unpredictable care-giving environments (e.g. Goodman, Patel, Oakes, Matho, & Triebwasser, 2013). A recent meta-analysis found individuals with BPD were more than three times as likely to report childhood adversity than other psychiatric groups, and nearly fourteen times more likely than non-clinical controls (Porter et al., 2020). BPD development is also predicted by sexual and physical abuse in infancy or childhood (M. Goodman et al., 2013). What's more this prediction persists even after controlling for symptoms of other personality disorders

(Chanen & Kaess, 2012). There is also evidence of BPD's roots in early attachment relationships via its association with maternal inconsistency (Bezirgianian et al., 1993).

Epistemic (mis)trust and (hyper/hypo)mentalization have been proposed as mechanisms by which these adverse early experiences may affect personality development (Fonagy & Luyten, 2009). In a sample of 111 clinically referred adolescents, Sharp et al. (2011) found children with higher BPD traits showed self-reported hypermentalizing. This was replicated by Bo and Kongerslev (2017), whose finding that BPD traits in adolescents were associated with poorer mentalizing irrespective of whether a categorical or dimensional approach was taken suggests the relationship between mentalizing and BPD is incremental. These disruptions in mentalizing are suggested to mediate the relationship between attachment organisation and BPD symptomology (Sharp et al., 2016). Unfortunately, neither Bo and Kongerslev (2017) nor Sharp et al. (2011) included a direct measure of epistemic trust in their studies and so the role of epistemic trust in this process must be inferred.

When considering the developmental aetiology of BPD, it is important to acknowledge that BPD often does not occur in isolation, but instead seems to relate to a propensity for other internalizing (e.g. anxiety, depression), externalizing (e.g. conduct disorder, oppositional defiant disorder) and personality disorders (Becker et al., 2000; Ha et al., 2014). For instance, Ha et al. (2014) reported significantly higher rates of psychiatric comorbidity of internalising and externalising disorders in hospitalised adolescents with BPD traits than those without. Again, this was true when using either a categorical or dimensional approach. So, it appears that the complex comorbidity that characterises adult BPD (Skodol et al., 2002) is also present in adolescents.

### ***Epistemic Mistrust and Psychopathy***

A particularly striking pattern of comorbidity exists between BPD and antisocial personality disorder (ASPD), or psychopathy, in both adults and adolescents (Becker et al., 2000; Chabrol & Leichsenring, 2006; Jovev et al., 2014; Sharp, Pane, et al., 2011). Psychopathy is defined by characteristics of impulsive antisocial behaviours, pathological lying, shallow emotions, manipulateness and a lack of guilt or remorse. In adolescents these are represented by a combination of callous-unemotional traits (CU) and conduct disorder (CD; Lee, Salekin, & Iselin, 2010). Like BPD, psychopathy too appears linked to interpersonal and behavioural regulation difficulties (Viding & McCrory, 2015) and adolescents with high levels of either trait show similar temperament patterns of higher reactivity and lower self-regulation (Jovev et al., 2014).

Development of psychopathic traits appears to be influenced by some of the same factors that affect BPD development. For instance, like BPD, the development of psychopathy also appears associated with maltreatment and neglect (see Viding & McCrory, 2015 for a conceptual review). A systematic review by Waller and colleagues (2013) showed that development of CU/CD is related to harsh and negative parenting and that children with high CU and CD are likely to have experienced “particularly compromised parental rearing environments” (Waller et al., 2013, p. 605), meaning more negative parental feelings, harsher discipline and more chaos in the home. The interconnected development of epistemic trust and mentalizing has not been directly tested in adolescents with psychopathic traits. However, on the basis of the literature reviewed thus far, it may be reasonably hypothesised that these experiences of trauma and maltreatment will negatively affect the development of epistemic trust, and future research should seek to directly test this in relation to CU/CD traits.

This is particularly pertinent as higher levels of trauma and maltreatment in childhood are associated with a variant of emerging psychopathy characterised by

high co-morbid anxiety (Cecil et al., 2018). In a study of socially deprived youths, Cecil and colleagues (2018) used self-report measures to assess CU traits, trauma history and anxiety. More extensive trauma experiences were found to be associated with a subgroup high in CU traits and high in anxiety (Cu+Anx) compared to those scoring lower on childhood trauma symptoms, who had high CU traits but low levels of anxiety (CU-Anx.; Cecil et al., 2018). It is yet untested whether these patterns of trauma predict the variants of emerging psychopathy or whether they simply correlate with them. Nonetheless, these high-low anxiety variants of childhood/adolescent psychopathy are reflective of the primary and secondary psychopathy subtypes that have been identified in the adult literature (Lee et al., 2010).

Though attachment style is considered to be generally disrupted in psychopathy (Viding & McCrory, 2015), Cecil et al. (2018) also showed that attachment patterns were interlinked with these high/low anxiety variants of psychopathy. The CU+Anx group were the least likely to report a secure attachment and were instead characterised by disorganised (45%) and avoidant attachment (32%) styles; while the CU-Anx group more closely mirrored the control group, with a majority demonstrating a secure attachment style (54%). Therefore, children showing high CU and high anxiety, who are more likely to have experienced trauma or abuse, show a similar pattern of attachment security to the those with BPD traits, who are also disproportionately likely to have experienced trauma. Indeed, this is consistent with research in adults showing that the high comorbid anxiety psychopathy variant shows significantly greater overlap with BPD traits than the low comorbid anxiety variant does (Skeem et al., 2003).

However, a note of caution should be observed when interpreting these findings. Anxiety was measured using a subscale of a trauma questionnaire (Trauma Symptom Checklist for Children; Briere, 1996), therefore you may expect high construct overlap between the measures of trauma and anxiety. The authors

defend the choice of anxiety measure by explaining that none of the anxiety sub-scale questions specifically reference trauma. However, it may be argued that items such as “feel afraid something bad may happen” or “feeling nervous or jumpy inside” link heavily to anxiety in a trauma context, and do not draw on the full range of possible anxious presentations. As such, future research would do well to include a broader measure of anxiety to test this relationship.

Though mentalizing has not been directly assessed, there is evidence that children with CD fail to accurately interpret situations and adjust their behaviour accordingly (Crick & Dodge, 1994). In the CD literature, this is described as a hostile attribution bias, wherein children with CD are more likely to interpret ambiguous social situations as threatening and respond to them aggressively (Crick & Dodge, 1994; Dodge et al., 1984). This is interpreted as a failure of information processing (Sharp & Venta, 2012), but it is also suggestive of a failure in mentalizing (Fonagy & Luyten, 2018b). Given the connectedness of mentalizing ability and epistemic trust, it is unsurprising that in an economic exchange game, such hostile attribution bias was linked with anomalies in trust and trustworthiness (Sharp, Ha, et al., 2011).

So like BPD, it appears emerging psychopathy is associated with disrupted attachment patterns and difficulties in accurately mentalizing others which links to patterns of trust and trustworthiness. Despite some shared developmental features, BPD and psychopathy have inverse differences in diagnostic prevalence between males and females: in BPD there is a higher diagnostic prevalence in females (M. Goodman et al., 2013), whereas in psychopathy there is a higher diagnostic prevalence in males (Cale & Lilienfeld, 2002). Is it possible that similar experiences of abuse or maltreatment present differently in females and males? Or, is it that sexist interpretations of behaviour have primed us (and our diagnostic methods) to detect emotionality in women, and destructive behaviour in men? To fully understand the developmental aetiology of either presentation and their bearing on epistemic trust and mentalizing, answers for these questions should be sought.

## **Interpersonal Relationships and Help Networks**

We will now consider the role of epistemic trust and mentalizing in facilitating engagement in broader social networks beyond those initial attachment relationships already discussed. Viewing the actions of others as goal-directed and intentional, and opening oneself up to communication enables efficient and appropriate social responses (Fonagy, Campbell, et al., 2017; Fonagy & Luyten, 2018a). This is because mentalizing others offers a sense of the 'why' behind the 'what' that is said or done, thereby increasing the likelihood of an appropriate response being elicited. Likewise, the experience of being mentalized, and so treated as an agentic object relaxes epistemic hypervigilance and opens channels for communication. This pattern of responsiveness enables the development of constructive interpersonal relationships characterised by confidence in one's own subjective experience that is tempered with an openness to learn from others.

As would be predicted, less functional patterns of social engagement are seen in individuals with disrupted epistemic trust and mentalizing (Fonagy, Luyten, et al., 2017a; Lazarus et al., 2014). For example, Bo and Kongerslev (2017) built on previous research by showing higher BPD traits were not only associated with poor mentalizing and problematic attachments to parents, but also to problematic attachments to peers. This is consistent with a systematic review that highlighted a range of interpersonal functioning difficulties in BPD, including: more negative expectations of relationships; poor social problem-solving skills; weaker cognitive empathy; and, decreased activation in areas associated with thinking about, or mentalizing, others (Lazarus et al., 2014).

The literature on interpersonal difficulties and BPD is vast and far beyond the scope of this review. However, it is acknowledged that studies of interpersonal functioning in BPD have been criticised for overreliance on vague or unidimensional measures of interpersonal functioning, such as the DSM-V Global Assessment of Functioning, which invites clinicians to assign a number between 1-100, reflecting a

'danger of severely hurting the self or others' through to 'superior functioning' (American Psychiatric Association, 2013; Clifton et al., 2007). Social Network Analysis (SNA) offers an alternative (Clifton et al., 2007; Lazarus & Cheavens, 2017). SNA provides a means to quantify and operationalize social relationships by inviting individuals to list people in their network and rate each relationship along a number of dimensions, such as perceived closeness, trust, criticism, and emotional support (Robins, 2015). In this way networks are defined by objective (e.g. network size) and subjective (e.g. perception of trustworthiness) qualities.

Using this approach, Clifton and colleagues found a number of differences in both the composition and the quality of social networks in a group of 11 adult patients with a BPD diagnosis, as compared to a group of 11 non-personality disordered clinical controls from the same service (Clifton et al., 2007). Participants were invited to list the thirty most important people in their life in the past year, and to rate them on a number of dimensions, including perceived closeness, trust, and conflict. Results showed the networks of the BPD group contained higher levels of conflict and a greater number of relationships that had been terminated, including former romantic partners. Particularly strikingly, while the control group rated more central relationships higher on positive features such as trust and closeness, the BPD group did not distinguish among their network, instead giving similar trust and closeness ratings for all members of their network. So, it appears the BPD group were characterised as trusting everyone and trusting no one.

Though revealing with regards to the quality of relationships, by asking all participants to list thirty people it was not possible to assess the quantity of relationships in the two groups. A more recent study corrected for this, and a paucity of both quality and quantity of relationships was found (Lazarus & Cheavens, 2017). Compared to healthy controls, women in the BPD group had smaller networks, which were characterised by lower levels of satisfaction and support, and higher levels of conflict and criticism.

Fonagy and colleagues have understood these interpersonal problems in the context of mentalizing failures that mean individuals frequently misinterpret others and also frequently find themselves misinterpreted (Fonagy & Luyten, 2009; Fonagy, Luyten, et al., 2017b, 2017a). A state of epistemic hypervigilance prevents this hypermentalizing from being corrected, and so the cycle of misunderstandings continues. This creates conflict, entrenches mistrust and risks these children being left without the social relationships necessary for normal healthy development (Bo & Kongerslev, 2017).

These health implications appear to be broader reaching than previously realised, with poor-quality social networks linked to mortality risk (Holt-Lunstad & Smith, 2015). Individuals with a personality disorder have a lower life expectancy than the general population, estimated by one study to be 18.7 years lower in females and 17.7 years lower in males in England and Wales (Fok et al., 2012). This shocking difference may, at least in part, relate to the distressing impact of poor social health. A meta-analysis by Holt-Lunstad and Smith (2015) reviewed seventy prospective studies of the relationship between social isolation and risk of mortality and found a strong relationship comparable to other well-established behavioural risk-factors, such as obesity, smoking or alcohol consumption. What's more, this relationship applied to both subjective measures of isolation, such as perceived loneliness or lack of support, and objective measures of isolation, such as size of social network or frequency of contact. The subjective perception of social isolation has also been linked to mental and physical health problems in a recent systematic review (Bhatti & Haq, 2017). For instance, those who judge themselves to have a deficit in social interaction were more likely to report depression, cognitive decline or problems with their cardiovascular or neuroendocrine systems.

So, it seems that difficulties in epistemic trust and mentalizing have clear ramifications for interpersonal relationships, which themselves predict mortality rates. It remains for epistemic trust and mentalizing to be examined in a single study

using social network analysis, an important step in understanding how these concepts relate. This framework could then be used to consider interpersonal difficulties in BPD, but also in emerging psychopathy: likewise known to be associated with epistemic trust and mentalizing difficulties that disrupt interpersonal relationships, yet where research is lacking.

### ***Therapeutic Relationships***

Epistemic trust and mentalizing may be especially important in the interpersonal relationship between therapist and client, particularly when the client is a child or adolescent (Fonagy & Allison, 2014). There are several reasons for this. First, by virtue of their age, children and adolescents have relatively limited experience engaging collaboratively with adults. This means the templates of epistemic trust and mentalizing formed in their attachment relationships are particularly influential in terms of whether (Shirk & Saiz, 1992) and how they will engage with their therapist (Bolton Oetzel & Scherer, 2003).

Second, the circumstances around which a child arrives at therapy mean they are not necessarily willing participants in the process (Shirk & Karver, 2003; Shirk & Saiz, 1992). Unlike adults, a child or adolescent is unlikely to refer themselves, may not have identified a problem, may be less distressed by what's going on and may not agree with the parents' goal (Shirk et al., 2011; Shirk & Saiz, 1992). As such, a child may find themselves in therapy, uncertain how they got there or what the purpose is. In this instance, it will be even more important for the child to feel mentalized and for this to establish epistemic trust in order to breakdown the natural vigilance and suspicion of the clinician (Fonagy & Allison, 2014).

Third, therapeutic relationships are typically focused around cultivating change in individuals who have, for whatever reason, become 'stuck'. Therapy invites clients to incorporate new information or perspectives. This ties inextricably to epistemic trust and an openness to learn. Only when the client perceives the therapist as having useful information and being appropriately motivated and trustworthy will the

epistemic superhighway open, and they will feel safe enough to change their position (Fonagy & Allison, 2014). Put simply: “in the absence of trust, the capacity for change is absent” (Fonagy et al., 2015, p. 591). Thus, the clients’ perception of the therapist, their experience of being thought about in therapy and their associated capacity to relax the natural state of epistemic vigilance and foster a sense of epistemic trust is crucial in therapeutic relationships. Through these processes, therapists may come to answer the questions: ‘what do you know?’ and ‘why should I listen?’.

This framework for therapeutic relationships may help explain why their formation seems more difficult in persons whose presentation is characterised by interpersonal difficulties, epistemic mistrust and mentalizing difficulties (Shirk & Karver, 2003). For example, clients with BPD are shown to have a high frequency of therapeutic alliance ruptures and therapeutic drop-out (Bennett et al., 2006). This may link to the previously discussed hyper/hypo-mentalizing and the associated mis-interpretations of behaviour, as well as the epistemic mistrust and an absence of learning, making it difficult to meaningfully engage the client (Fonagy, Campbell, et al., 2017; Fonagy et al., 2015). Indeed, from a series of case vignettes of clients with BPD, Bo and colleagues (2017) have suggested that to address hypermentalizing and epistemic mistrust in the therapeutic relationship, therapists must strive to work exclusively in ‘we-mode’, ensuring collaborative participation that invites a shared understanding by acknowledging each other’s minds and contributions to a goal.

With regards to psychopathy, therapeutic relationship formation in children with externalising problems appears to be “more challenging and more critical for outcome” (Shirk & Karver, 2003, p. 461). Yet, the picture is muddled by mixed results and over-interpretations of data. For instance, in a sample of justice-involved adolescents’, higher CU traits signalled a significant and positive association between therapeutic alliance and previous offences (Simpson et al., 2013). In

contrast, the association was negative, but not significant, in those with low levels of CU traits. From this the authors inferred that those high on CU traits are more socially skilled and able to establish positive therapeutic alliances, even if they are superficial or manipulative.

In fact, if you look at the data, in the high previous offence group the difference in therapeutic alliance rating between the high and low CU individuals is negligible, whilst in the low previous offence group, the high CU trait group seem to make much lower ratings of the therapeutic alliance. Yes, the gradient of the association may be different, but so is the absolute value of the datapoints. This does not seem to suggest that CU traits relate to better therapeutic alliance in high offence groups, but that they relate to worse therapeutic alliances in the low offence group. We may more appropriately wonder why the low offence-high CU group make such low ratings of the alliance. The conclusions of the authors may misrepresent the data, and it is clear that further understanding and analysis is needed, particularly with the use of an antisocial behaviour measure not contingent on reported and prosecuted offences. It also remains unclear how the high-low anxious subdivision of psychopathy relates to the therapeutic alliance and this too should be included in future research.

This understanding of how psychopathology impacts the therapeutic alliance is crucial because therapeutic alliance predicts therapeutic outcome (Horvath, 2000; Horvath & Symonds, 1991; Krupnick et al., 1996). Research has consistently shown that in both adults and young people, therapeutic outcomes are predicted by clients' subjective views of the relationship; but, not by objective measures of the alliance nor therapists' perceptions of the relationship (see Horvath, 2000). This suggests that there is something uniquely important about how the client perceives the relationship. However, it remains unclear how this influence is borne out. One way would be through correlations with clients' epistemic trust and mentalizing abilities, which would in turn influence their openness to learning and change. This would be

consistent with the known effect of epistemic trust and mentalizing abilities on interpersonal relationships, and that difficulties in these areas characterise the presenting problems most often associated with poor therapeutic relationships. However, future research is needed to directly test this possibility.

### **Literature Summary**

Therapeutic alliance and social network engagement vary in relation to psychopathology. The literature reviewed here suggests differences in mentalizing and epistemic trust may offer a credible explanation for this. In a clinical setting, these epistemic trust and mentalizing difficulties may render the child 'hard to reach' (Fonagy, Campbell, et al., 2017), or perhaps more accurately, make it hard for us to reach them (Fonagy et al., 2015). This difficulty engaging is likely to extend beyond the therapeutic alliance into broader social network relationships. This account seeks to draw together in outline what is already known and it is for future research to test this directly.

### ***Methodological Issues***

Methodology is the cornerstone of research. For meaningful inferences to be drawn, one must have confidence in the accuracy, reliability and validity of measurements. Throughout this literature review, conclusions have been interpreted in the context of the methodology used to draw them, in some instances, leading to a less persuasive picture than the authors would have had the reader believe. Therefore, as future research, including that which follows in Chapter 2 of this thesis, seeks to address the questions raised here, it is imperative they do so with a firm methodological grounding.

Take the extensive use of self-report measures in the literature. A review by van de Mortel (2005) highlights a number of problems with self-report questionnaires, centred around a desire to present a favourable image of oneself. Participants may be aware of their tendency to give socially desirable responses ('faking good') or they may believe what they report (self-deception), either way the

tendency increases when a questionnaire concerns a socially sensitive topic. Yet, self-report measures are still used extensively throughout the psychology literature and consideration of the reliability and validity of individual questionnaires may present a more optimistic picture. As an example, look at the Borderline Personality Features Scale for Children (BPFS-C; Crick et al., 2005). This 24-item self-report measure was adapted from the borderline subscale of the Personality Assessment Inventory (Morey, 2014), which is reported to be a valid and reliable measure. The BPFS-C has been shown to have: a high-internal consistency (e.g.  $\alpha = .91$ , Chang, Sharp, & Ha, 2011;  $\alpha = .90$ , Bo & Kongerslev, 2017); high accuracy in discriminating adolescents with a diagnosis of BPD (Chang et al., 2011); and, good concurrent validity and cross-informant concordance (Sharp, Mosko, et al., 2011). What's more, studies used to validate it draw on different sample populations: inpatient clinical samples (Chang et al., 2011); outpatient clinical samples (Bo & Kongerslev, 2017); and community samples (Sharp, Mosko, et al., 2011). Therefore, though there may be some general concerns around socially desirable responding, this example of the BPFS-C shows how self-report questionnaires can be used to usefully identify and distinguish certain psychopathology traits in children and adolescents.

The same may be said for other measures of psychopathology in the literature discussed here, such as the Inventory of Callous-Unemotional Traits (ICU; Frick, 2004), which has good factorial validity, convergent validity, concurrent validity and criterion validity (Roose et al., 2010). Likewise, there is compelling evidence for the importance of self-report therapeutic alliance measurements (Horvath, 2000). As discussed, these seem uniquely suited to capture the clients' perspective and their predictive value in terms of therapeutic outcomes goes above and beyond that of an observer's perspective, or the perspective of the clinician. Thus, though it is important to hold in mind the limitations of self-report measures, it seems that

selection of appropriately validated ones can allay some of these concerns and provide an important contribution.

Moving beyond the predictiveness of direct self-report, it has not yet been explored how the client's assumed perspective of the clinician may influence engagement in the therapeutic relationship or relate to the client or clinician's actual judgment of the relationship. It is not known how this ability to mentalize the therapist's opinion of themselves may relate to certain psychopathologies, or in turn whether this may provide an improved predictor of engagement in therapy. This ability to mentalize the therapist's opinion of themselves may well be pivotal in the opening of the epistemic 'superhighway' and may represent a defining feature of therapeutic success.

Finally, while it is beyond the scope of this review to offer a comprehensive overview of the literature on interpersonal difficulties and BPD, it does appear that the use of SNA has contributed to understanding in this field. Much as the use of SNA in general BPD research opened-up a more detailed understanding of how interpersonal differences develop and perpetuate, so the use of SNA in conjunction with assessments of epistemic trust and mentalizing abilities will help us to understand the role these key constructs play.

### **Research Questions**

Presented here is an incomplete picture of the relationship between psychopathology, epistemic trust, mentalizing, therapeutic expectations and social networks. Many questions remain. For instance, despite shared disruption in epistemic trust, does childhood trauma cause differential presentations in males and females? How does comorbid anxiety in emerging psychopathy influence engagement in the therapeutic alliance? Does improvement in mentalizing capacity track with improvement in the therapeutic alliance and therapeutic outcome? To answer all these questions is far beyond the scope of this thesis. As such, the focus is limited to the way in which epistemic trust and mentalizing affect the therapeutic

relationship in adolescents. This will be viewed in the framework of attachment style, childhood trauma, and psychopathology, with particular attention paid to BPD traits and psychopathy traits, in order to consider if factors known to affect epistemic trust and mentalizing have a similar bearing on therapeutic relationships. Broader social network analysis will be used to contextualise the therapeutic relationship within the individual's help-network.

A novel approach will be used to assess client views of the therapeutic relationship: adolescents will complete a self-report measure of therapeutic alliance from their own perspective ('own') and from the presumed perspective of the therapist ('presumed') and the therapist will complete the measure from their own perspective ('actual'). These three interpretations of the therapeutic alliance will then be contrasted, allowing direct assessment of the young person's ability to mentalize themselves in the therapist's mind, and how this compares to their own view of the relationship. This will be compared to more general self-report measures of mentalizing and epistemic trust.

It is hypothesised that clients' own and presumed clinician judgments of the alliance will relate positively to epistemic trust and mentalizing skills, but clinician judgments will not. Symptoms of psychopathology are predicted to influence this, with anxiety and trauma history impacting levels of epistemic trust. Discrepancy in presumed and actual clinician judgments are predicted to be related to symptoms of BPD and psychopathy but in an inverse fashion: with BPD linked to higher actual than presumed judgments; and psychopathy linked to higher presumed than actual judgments. The effect of epistemic trust and mentalizing is also predicted to extend to the broader social network, with less variation among ratings of closer and more distant ties predicted for those with lower epistemic trust and higher psychopathology.

## **Conclusions**

This review has sought to give a broad outline of what is currently known about how epistemic trust, mentalizing, therapy expectations and psychopathology relate in adolescents. There is considerable evidence regarding the importance of epistemic trust, its connection to attachment and mentalizing abilities, and how the development of these are interlinked. It has been seen that these abilities may be adversely affected in certain psychopathologies, namely BPD. There is also some emerging evidence that other psychopathologies which share key aetiological features, such as childhood maltreatment or trauma, may also show difficulties in these areas. Of particular interest here has been emerging psychopathy and more should be done to understand the role of epistemic trust, mentalizing and attachment in this group. These abilities have been linked with engagement in therapeutic relationships and used to aid understanding of difficulties in doing this, perhaps offering context to why the therapeutic process is so challenging for some young people. Moving beyond the therapeutic relationship, it has also been considered how these difficulties may reflect engagement in broader social and help networks. Many interesting questions remain regarding how these areas associate and by addressing these, a more informed approach can be taken to engaging some of the young people we find most difficult to reach.

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## **Part 2: Empirical Paper**

### **Epistemic Trust and Mentalizing in Adolescent Therapeutic Alliances**



## **Abstract**

**Aims:** This study sought to explore whether epistemic trust and mentalizing predict therapeutic alliance and broader social network engagement in adolescents. These patterns were considered in relation to attachment style and psychopathology, in particular borderline personality disorder and psychopathy.

**Method:** A series of self-report questionnaires were used in a sample of adolescents currently engaging in therapy, with a novel approach used to break-down client alliance views. Due to COVID-19 the sample size was smaller than planned (n = 16 rather than n = 40), requiring adjustment to the design and scope of the analysis.

What followed was, therefore, a restricted but theory driven exploration of the broad study concepts.

**Results:** There is preliminary evidence of an association between epistemic trust and client therapeutic alliance judgments, in particular what clients presume clinicians think of the alliance. Suggestive patterns also emerged in relation to social network variables, in particular that client alliance judgments may relate to perceived emotional support from professionals.

**Conclusions:** Epistemic trust could be important in the formation of therapeutic alliances and broader social network engagement. The findings suggest that how clients interpret clinicians' views of the alliance may be important for alliance formation. If replicated with larger samples, the observed associations would imply that greater notice should be paid to client attempts to mentalize the clinician. The limitations of the research are discussed and avenues to be explored in the future are outlined.

## Introduction

Social support and interpersonal functioning are vital for wellbeing. From a physical health perspective, social support influences both the likelihood of developing a disease and how an established disease progresses (for a review see: Uchino, 2006). Strikingly, the effect of social isolation and the absence of social support on health and mortality is comparable to that of other known risk factors, such as smoking and obesity (Bhatti & Haq, 2017; Holt-Lunstad & Smith, 2015). From a mental health perspective, social support influences the development and maintenance of difficulties (Mundt et al., 2017; Vandervoort, 1999), as well as the ability to engage with and benefit from treatment (Borkovec et al., 2002). Moreover, the influence appears causal, for instance with interpersonal functioning deficits in adolescence predicting the onset of depression in early adulthood (Eberhart & Hammen, 2006), whilst good social support acts as a protective factor to enhance resilience to stress (Ozbay et al., 2007).

The impact of social support on health is qualified along two dimensions: a structural dimension concerning network size; and, a functional dimension concerning quality of interactions gauged on components such as emotional and practical support (House, 1987; House et al., 1985). Though both appear to impact mental wellbeing, the effect of the functional quality dimension is often more pronounced (Vandervoort, 1999) with much of the literature focusing on this. Interestingly, this latter dimension of perceived, not actual, social support is more routinely associated with wellbeing. For example, perceived lack of social support in early childhood is predictive of mental health difficulties in both adolescence (Qualter et al., 2010) and adulthood (Vilhjalmsson, 1994; Windle, 1992). Perception of social support from friends and family also predicts depressive symptoms and suicidal ideation in adolescents (Kerr et al., 2006), and perceived social isolation has the same impact on mortality as objective social isolation (Holt-Lunstad & Smith, 2015). So, it appears that the subjective nature of these perceptions captures

something important in understanding their impact on wellbeing that is missed by objective judgments.

The subjective perception of a relationship is particularly important in therapeutic alliances, where client alliance ratings consistently predict therapeutic engagement and outcomes, but therapist and observer alliance ratings do not (Holdsworth et al., 2014; Horvath & Symonds, 1991; Krupnick et al., 1996). This pattern emerges as early as session three and persists across therapy, irrespective of treatment, clinical diagnoses and client population (for a review see Horvath, 2000). There is some suggestion that client and therapist alliance judgments are made on the basis of different criteria, for instance the former relates to emotional support (Pinto et al., 2012) and the latter to therapist confidence and dedication (Bachelor, 2013). Though most of the therapeutic alliance research has been based in adults, the same pattern has been found in children and adolescents (Shirk et al., 2011; Shirk & Karver, 2003), with capacity to engage adolescents in the alliance crucial for optimizing therapy (Karver et al., 2019). Moreover, research seeking to separate the temporal confounds of the association have shown a causal link between alliance and outcome in adolescent therapy (Chiu et al., 2009; Labouliere et al., 2017).

Indeed, the impact of perceptions of the therapeutic alliance may be even more pronounced for children and adolescents as: they are less likely to refer themselves for therapy (Shirk et al., 2011); they have limited experience engaging collaboratively with adults, which will make it harder to find the shared intentionality that Gallotti and Frith termed “we-mode” (Bo et al., 2017; Gallotti & Frith, 2013); and, the power dynamic between therapist and client (De Varis, 1994; Kuyken, 1999) is liable to be accentuated due to the societal distribution of power to the adult in child-adult interactions. Each of these is likely to pose a barrier to adolescents’ ability to engage in therapy. What is more, theories of development suggest adolescents are in a point of transition, in which they will encounter new experiences, new emotions

and new ways of managing this. For instance, Elkind's (1967) theory on egocentrism suggests they are likely to have quite egocentric cognitive biases, that may make it harder to connect with others, or to feel that someone outside their social group may empathise with them or have knowledge that might benefit them. Erikson's (1956) developmental model suggests this may be compounded by a search for autonomy and ego identity, which at times leads to a rejecting or hostile attitude towards adult figures. Thus, adolescents are at a developmental stage which may provide several barriers for them engaging in treatment. So it seems development of a therapeutic alliance is not simply an early therapy task to be completed and set-aside, but instead is a crucial re-occurring process on which the on-going success of the therapy hinges (Shirk et al., 2011).

Taken together, these findings show the potential relevance of interpersonal interactions on mental wellbeing, which relies on the subjective perception of the interaction. This is important because there are long-term implications for interpersonal functioning on development and wellbeing across the lifespan. Moreover, as well as contributing to development of mental health issues, this affects ability to engage in and benefit from therapy. This raises three distinct but interrelated questions that this study seeks to address: what influences perceptions of adolescent therapeutic alliances; do these factors vary with nature of presentation; and, how does this relate to engagement in the broader social network?

The answers may lie in a construct not usually considered in the psychotherapy literature: epistemic trust. Epistemic trust refers to trust in the authenticity and relevance of information shared by another. Epistemic trust has been suggested to allow for the efficient communication of socially and culturally relevant information (Csibra & Gergely, 2009). However, to protect against potentially harmful misinformation, epistemic trust is not guaranteed and must be cultivated (Sperber et al., 2010). One of the key means for doing this may be

mentalizing: the process of understanding one's own and others' actions as intentional and goal directed (Fonagy & Allison, 2012). Mentalizing acts as an ostensive cue by recognising the individual as an intentional agent and making communication more personally relevant (Fonagy et al., 2015). This cultivates epistemic trust in two ways: first, an individual's own mentalizing skills develop, better enabling them to judge the motivations of the communicator and to respond accordingly; and second, communication that acknowledges an individual's agency increases the chances of the communication being perceived as personally relevant.

In therapeutic relationships this means clients with better mentalizing skills are more likely to develop epistemic trust with their therapist, which in turn enables them to assimilate new information more readily and to feel safe enough to change their prior beliefs (Fonagy et al., 2015). In contrast, clients with poorer mentalizing skills are more likely to show epistemic mistrust or vigilance with their therapist, and so will seem harder to engage and less likely to benefit from the therapy (Fonagy & Allison, 2014). For this reason, high levels of epistemic mistrust has been proposed as an explanation for a general difficulty in engaging in psychosocial treatment and as a predictor of poor treatment outcomes (Fonagy et al., 2015; Fonagy, Luyten, et al., 2017a, 2017b). Moreover, this impact extends beyond the therapeutic alliance to engagement in broader social networks, enabling individuals to benefit to a greater or lesser degree from interpersonal interactions (Fonagy et al., 2007).

The development of epistemic trust and mentalizing are tied to attachment security (Corriveau et al., 2009; Fonagy et al., 2007), which is itself a predictor of therapeutic alliance strength (Bernecker et al., 2014; Diener & Monroe, 2011). The relationship between attachment and alliance may be mediated by mentalizing and interpersonal functioning (Bernecker et al., 2014). Bernecker et al. (2014) suggest this is corroborated by demonstrations that it is more challenging to form therapeutic

alliances with individuals with disrupted attachment and poor interpersonal and mentalizing skills.

A clinical group which may present with this pattern of social cognitions are individuals who are diagnosed with borderline personality disorder (BPD; Fonagy & Luyten, 2009). Impairments in mentalizing, attachment security and the associated difficulties of epistemic vigilance and poor social interactions are well documented as contributing to the development and maintenance of BPD (Clifton et al., 2007; Fonagy et al., 2015; Fonagy, Luyten, et al., 2017a). What is more, individuals with BPD show particular difficulty engaging in the therapeutic alliance (Bennett et al., 2006) and show relatively poor therapeutic outcomes (Kongerslev et al., 2015). We may speculate that this could be attributed to a cycle of epistemic hypervigilance preventing new learning and correction of hypermentalizing errors, meaning an individual persists in a state of mistrust and misunderstanding (Fonagy, Luyten, et al., 2017a).

This pattern also typifies other presentations linked with attachment and interpersonal difficulties, such as psychopathy: characterised in adolescents as a combination of callous unemotional traits and conduct disorder (Frick et al., 2014). Like BPD, psychopathy is associated with: disrupted attachment (Viding & McCrory, 2015); mentalizing difficulties (Fonagy & Luyten, 2018b; Sharp & Venta, 2012); poorer therapeutic alliance (Kazdin & Durbin, 2012); and, worse therapeutic outcomes (Manders et al., 2013). Also like BPD, impairments in epistemic trust are thought to drive the interpersonal communication difficulties that impair the therapeutic process (Fonagy & Luyten, 2018b). Indeed, as Fonagy and colleagues have suggested: “we see the destruction of trust in social knowledge as the key mechanism in pathological personality development” (Fonagy et al., 2015, p. 589).

While such speculations have coherence and a certain intellectual force they are not grounded in empirical observations. The present study sought to bring together these areas of research and explore whether individual differences in

adolescent perceptions of the therapeutic alliance may be understood in terms of epistemic trust and mentalizing abilities. Of particular interest was the question whether epistemic trust and mentalizing differences drive alliance judgments and whether this could account for the limited impact of therapy on some presentations, specifically BPD and psychopathy. To test this, it was important to separate out what clients think of the therapist and what they believe the therapist thinks of them, with the latter hypothesised as more closely linked to epistemic trust and mentalizing. So, a somewhat novel approach was taken in this study with clients being requested to complete The Scale to Assess Therapeutic Relationships (STAR; McGuire-Snieckus et al., 2007) from both their own and the presumed perspective of the clinician. The STAR was used as it was specifically developed to compare client and therapist views, unlike most other measures originally designed to capture only one perspective (Ardito & Rabellino, 2011).

To facilitate comparison with therapists' alliance judgments, the adolescents' therapists were also asked to complete the STAR from their own perspective, enabling contrast of actual clinician ratings and client presumed clinician ratings. Alliance ratings were considered in relation to client engagement in social networks, in order to understand how epistemic trust patterns in the social network may generalise to the relationship with the therapist. Both the structural and functional aspects of the social network were explored in relation to client and clinician ratings. Particular attention was paid to the domains of emotional, practical and information support, which were drawn from previous research in to the components of social support and which were intended to reflect the different kinds of help individuals may receive (House, 1987; House et al., 1985).

It was hypothesised that epistemic trust and psychopathology would predict clients' own and presumed clinician alliance judgments, but not actual clinician alliance judgments. More specifically, it was hypothesised that epistemic trust would account for variance in alliance judgments above and beyond that accounted for by

BPD and psychopathy traits alone. Mentalizing was hypothesised to relate to these variables, with epistemic trust moderating the relationship between mentalizing and therapeutic alliance. Broader social support constructs relating to quality, such as perceived emotional support or frustration, were predicted to relate to epistemic trust and to clients' own judgments but not clinicians' judgments. Clinician judgments were predicted to relate to more quantifiable and structural social network components, such as frequency of contact.

## **Method**

### ***Participants***

Participants were recruited from three NHS Child and Adolescent Mental Health or Substance Use Services and a UK charity which offers adolescents free psychotherapy. Inclusion criteria were being aged 12-18 years-old; having attended at least three therapy sessions; and, being able to fill in questionnaires unsupported. The literature identifies the third therapy session as a point from which therapeutic alliance appears established and predictive of therapeutic outcome (Hilsenroth et al., 2004; Horvath, 2000; Paivio & Bahr, 1998), and so this number of sessions was included as a minimum requirement for participation. Participants had a mean of seventeen therapy sessions prior to taking part in the study (SD = 10). Participants were offered a £20 Love2Shop voucher to thank them for their time.

An a priori power analysis was conducted using G\*Power3.1 (Faul et al., 2007) to test the relationship between variables in a multiple regression analysis, using  $\alpha = .05$  and achieving a power of .8. No published effect sizes of the STAR and measures of epistemic trust or psychopathology were available, and so effect size was drawn from three studies using related alliance instruments in youths. These indicated similar numbers of participants were required:  $n = 30$  ( $r = -.27$ ; Duppong Hurley et al., 2017);  $n = 38$  ( $r = .22$ ; Hawley & Garland, 2008); and,  $n = 40$  ( $r = -.21$ ; Bickman et al., 2012). As such, a conservative position was taken to recruit 40 participants. However, recruitment had to be prematurely ceased due to COVID-

19 restrictions. There is an intention to re-start recruitment once restrictions lift with a view to adding further participants to enable the study to be written for publication. In any event, for the purpose of this thesis sixteen participants were recruited (11 females, 5 males; mean age = 17.06, SD age = 1.12).

### ***Design***

A between-subjects, observational design was used to compare adolescents' levels of epistemic trust in relation to their therapeutic alliance and social network patterns. Adolescents completed a battery of self-report quantitative questionnaires at a single time-point: nine of these were from the adolescent's own perspective and measured epistemic trust, mentalizing, therapeutic alliance, attachment, psychopathology and social network; and one was from the presumed perspective of the clinician and measured therapeutic alliance. This latter questionnaire was to be compared to the clinician's actual ratings of the alliance to capture how accurately the adolescent mentalized the therapeutic alliance. Clinicians also completed the social network questionnaire regarding the adolescents' support network.

### ***Procedure***

Clinicians from participating services were asked to share information about the study with their clients who met the inclusion criteria. If participants expressed an interest, their details were passed on to the researcher and a face-to-face testing session was arranged at the service referring them. Participants were given an information sheet (example shown in Appendix A) and completed a consent form (example shown in Appendix B). Participants completed the battery of questionnaires on a computer in one session. They were debriefed and received a voucher on the same day. After testing, the participant's clinician was invited to complete their questionnaires on paper and return these to the researcher on the following visit to the research site.

## **Measures**

Demographic information was collected regarding participants' age, gender and the number of therapy sessions they had had at time of testing. All participants completed the following eight self-report questionnaires:

### **Epistemic Trust Scale (ETS; Appendix C; Luyten et al., under development).**

The ETS is a 24-item measure of epistemic trust that is currently under development. There are two sub-scales, each comprised of twelve items: epistemic trust for psychotherapist, e.g. 'I think that my psychotherapist would always be honest with me'; and, epistemic trust of others, e.g. 'I love learning from new people'. Each item is rated on a seven-point Likert scale from strongly disagree (1) to strongly agree (7) with fourteen items reverse scored. Higher scores reflect higher levels of epistemic trust. There are no published psychometrics for the ETS yet, however, the internal consistency in the present sample was good for both the total  $\alpha_{total} = .79$  and the two subscales,  $\alpha_{psychotherapist} = .79$  ;  $\alpha_{other} = .68$ .

**Reflective Function Questionnaire (RFQ; Fonagy et al., 2016).** The RFQ is a measure of mentalizing in which 46 statements are rated on a six-point Likert-type scale from strongly disagree to strongly agree. It comprises two subscales: certainty (RFQ\_C) and uncertainty (RFQ\_U) about the mental states of the self and others, with higher scores reflecting hypermentalizing and hypomentalizing respectively. Both subscales are derived from the same seventeen items and as more moderate answers are considered to reflect the opaqueness of mental states, the six possible responses are scored as either 2, 1, 0, 0, 0, 0 or, 0, 0, 0, 0, 1, 2 with the items reverse scored between the two sub-scales. For example, for the item "People's thoughts are a mystery to me" a response of 'strongly disagree' would score 2 in the RFQ\_C scale and be indicative of hypermentalizing, whilst it would score 0 on the RFQ\_U scale. Conversely, a response of 'strongly agree' to the same item would score 0 for the RFQ\_C, but 2 for the RFQ\_U and would be seen as indicative of hypomentalizing.

Both subscales have satisfactory internal consistency ( $\alpha_{\text{RFQ}_C} = .67$ ,  $\alpha_{\text{RFQ}_U} = .63$ ) and excellent test-retest reliability ( $r_{\text{RFQ}_C} = .75$ ,  $r_{\text{RFQ}_U} = .84$ ; Fonagy et al., 2016). In the present sample, the internal consistency of the RFQ\_U subscale was good ( $\alpha_{\text{RFQ}_U} = .74$ ), but the internal consistency of the RFQ\_C subscale was poor ( $\alpha_{\text{RFQ}_C} = .44$ ). A comparably low Cronbach's alpha was found in one of three development studies reported by Fonagy et al. (2016) and this was attributed to the average score being very low, meaning there was not an adequate range of scores to allow internal consistency to be accurately calculated. In the present sample, out of the seventeen items in the subscale, the median number of items not scoring zero was 3, suggesting a low overall variance of items, which will reduce the correlation between items and so reduced the Cronbach's alpha. This seems consistent with Fonagy and colleagues' (2016) account and so their approach to proceed with data analysis and interpret findings with caution was also taken here.

**Scale to Assess Therapeutic Relationship (STAR; McGuire-Snieckus et al., 2007).** The STAR is a 12-item measure of patient (STAR-P) and clinician (STAR-C) views of the therapeutic alliance. Both versions are comprised of three sub-scales: positive collaboration, e.g. 'My clinician and I are open with one another' or 'I get along well with my patient'; positive clinician input e.g., 'My clinician and I share a trusting relationship' or 'I listen to my patient'; and, either non-supportive clinician input (STAR-P), e.g. 'I believe my clinician withholds the truth from me', or, emotional difficulties (STAR-C) e.g. 'I feel inferior to my patient'. Items are rated never (0), rarely (1), sometimes (2), often (3) or always (4), with items from the non-supportive clinician and emotional difficulties subscale reverse scored. Scores are then summed, with higher scores indicating a more positive therapeutic alliance.

For the client version, good test-retest reliability and internal consistency has been demonstrated for the overall score ( $r = .76$ ;  $\alpha = .83$ ) and the positive collaboration ( $r = .78$ ;  $\alpha = .91$ ), positive clinician input ( $r = .81$ ;  $\alpha = .86$ ) and non-

supportive clinician input ( $r = .68$ ;  $\alpha = .76$ ) subscales (Loos et al., 2012; McGuire-Snieckus et al., 2007). Likewise, for the clinician version, good test-retest reliability and internal consistency has been demonstrated for the overall score ( $r = .68$ ;  $\alpha = .87$ ) and the positive collaboration ( $r = .72$ ;  $\alpha = .94$ ), clinician emotional difficulties ( $r = .58$ ;  $\alpha = .88$ ) and positive clinician input ( $r = .73$ ;  $\alpha = .73$ ) subscales (Loos et al., 2012; McGuire-Snieckus et al., 2007). In the present sample, internal consistency for the client version was good ( $\alpha = .80$ ) and for the clinician version it was acceptable ( $\alpha = .62$ ).

**Attachment Questionnaire for Children (AQC; Muris et al., 2001).** The AQC is a single-item measure of attachment style, where items were adapted from the original adult version to make them more easily understood by young people (Sharpe et al., 1998). Participants read through and select which of three statements most accurately describes them and attachment style is then classified as secure, avoidant or ambivalent. Internal consistency cannot be calculated as the measure is comprised of one item only, however it has been shown to have good concurrent validity with other established measures of attachment, such as the Inventory of Parent and Peer Attachment (see Muris et al., 2001). Though the measure was adapted for use with children, research suggests that it can appropriately be used with adolescents for the purpose of broad attachment categorisation because its adaptation involved making each of the statements more easily understood by younger people, including in adolescence (Muris et al., 2001; Nelis & Rae, 2008). Attachment was not a key variable of interest in the present study, which sought only to offer a broad categorisation of participant attachment styles. As such, to avoid adding undue questions to the battery and increasing demand on participants, this brief adapted version was felt appropriate for the present purposes.

**Social Network Analysis Questionnaire** (Appendix D and E). These questions aimed to assess both quantity and quality of participants' social networks. First, participants were asked to identify people they regarded as supportive and to list up to five with whom they had a personal relationship and up to five with whom they had a professional relationship. The relationship with each identified person was then assessed using nine questions rated on a five-point Likert scale from Never/Not at all (1) to Always (5). Questions were designed for the purpose of this study to tap into perceptions of helping relationships with regards to frequency of contact, help seeking, understanding, emotional support, practical support, informational support, reliability, frustration and trust. The internal consistency of these items in the present sample was good,  $\alpha = .80$ .

**Revised Child Anxiety and Depression Scale** (RCADS; Chorpita et al., 2000). The RCADS is a measure of symptoms of anxiety and low mood. Participants rate whether 47 statements never (0), sometimes (1), often (2) or always (3) apply to them. All items are summed for an overall measure of internalising problems, or it can be broken down in to six-subscales capturing: generalised anxiety disorder, e.g. 'I worry about things'; social anxiety disorder, e.g. 'I worry I might look foolish'; separation anxiety disorder, e.g. 'I worry about being away from my parents'; panic disorder, e.g. 'When I have a problem I feel shaky'; obsessive compulsive disorder, e.g. 'I have to keep checking I have done things right'; and, major depressive disorder, e.g. 'I feel sad or empty'. Age and gender are used to transform raw scores to t-scores on the basis of normative data, with 50 being the mean and higher scores indicating higher symptoms (Chorpita et al., 2005). Excellent psychometric properties have been demonstrated, with the subscales showing internal consistency:  $\alpha_{\text{SAD}} = .78$ ,  $\alpha_{\text{SP}} = .87$ ,  $\alpha_{\text{OCD}} = .82$ ,  $\alpha_{\text{PD}} = .88$ ,  $\alpha_{\text{GAD}} = .84$ ,  $\alpha_{\text{MDD}} = .87$  (Chorpita et al., 2005); and good test-retest reliability,  $\alpha_{\text{SAD}} = .72$ ,  $\alpha_{\text{SP}} = .85$ ,  $\alpha_{\text{OCD}} = .63$ ,  $\alpha_{\text{PD}} = .71$ ,  $\alpha_{\text{GAD}} = .71$ ,  $\alpha_{\text{MDD}} = .84$  (Chorpita et al., 2000).

Internal consistency in the present sample was not assessed as this measure was excluded from sample analysis.

**Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997).** The SDQ is a 25-item measure of emotional and behavioural problems. There are five subscales, each comprised of five questions: emotional symptoms, e.g. 'I am often unhappy, down-hearted or tearful'; conduct problems, e.g. 'I get very angry'; hyperactivity/inattention, e.g. 'I am restless'; peer problems, e.g. 'I am usually on my own'; and, prosocial behaviour, e.g. 'I usually share with others'. The first four subscales can be summed to produce a total difficulties score, with higher scores on each of these indicating greater difficulties, whilst a higher score on the prosocial behaviour scale indicated higher prosocial behaviour, which is regarded as a positive. Participants rate each item as 'not true' (0), 'somewhat true' (1) or 'certainly true' (2), with five items reverse scored. Total and subscale scores are categorised as 'close to average', 'slightly raised', 'high' and 'very high' as compared to UK population averages. The self-report SDQ difficulties score has good internal consistency for the total difficulties score ( $\alpha = .80$ ) and there is satisfactory internal consistency in the subscales of emotional symptoms ( $\alpha = .66$ ), conduct problems ( $\alpha = .60$ ), hyperactivity-inattention ( $\alpha = .67$ ) and prosocial behaviour ( $\alpha = .61$ ; Goodman, 2001). However, the peer problems subscale had unacceptable internal consistency ( $\alpha = .41$ ) and so will be excluded from analysis. Internal consistency of the SDQ in the present sample was not assessed as this measure was excluded from sample analysis.

**Antisocial Beliefs and Attitudes Scale (ABAS; Butler et al., 2007, 2015).** The ABAS is a measure of conduct disorder traits loading on to two factors: rule non-compliance, e.g. 'It's no big deal to skip a few classes'; and peer conflict, e.g. 'Some young people deserve to be picked on'. Participants are asked to indicate if they agree (2), are unsure (1) or disagree (0) with statements, with some prosocial

items reverse scored. Each factor comprised nine questions. Higher scores reflect higher endorsement of antisocial beliefs and attitudes. Good psychometric properties have been demonstrated with regards to reliability and internal consistency for both rule non-compliance ( $r = .83$ ;  $\alpha = .8$ ) and peer conflict ( $r = .77$ ;  $\alpha = .77$ ; Butler et al., 2015). Internal consistency in the present sample was not assessed as this measure was excluded from sample analysis.

A subset of participants ( $n = 7$ ) also completed the following additional three measures. This was determined by the service that referred them, with participation of one service contingent on removing the following questionnaires from the battery.

**Borderline Personality Features Scale – Children (BPFS-C; Crick et al., 2005).** The BPFS-C is a 24-item measure of borderline personality traits in children, with higher scores indicating more borderline features. There are four subscales: affective instability, e.g. 'I go back and forth between different feelings, like being mad or sad or happy'; identity problems, e.g. 'I worry that people I care about will leave and not come back'; negative relationships e.g. 'I feel very lonely'; and, self-harm, e.g. 'When I get upset, I do things that aren't good for me'. Each subscale comprises six items. Items are rated on a five-point Likert scale, from 'Not at all true' (1) to 'Always True' (5), with four items reverse scored. Higher scores indicate higher BPD features. The BPFS-C has good internal consistency ( $\alpha = .76$ ; Crick et al., 2005). Internal consistency in the present sample was not assessed as this measure was excluded from sample analysis.

**Inventory of Callous-Unemotional Traits (ICU; Frick, 2004).** The ICU is a 24-item measure of callous and unemotional traits in young people. There are three sub-scales: Callousness, e.g. 'The feelings of others are unimportant to me'; Uncaring, e.g. 'I do not care who I hurt to get what I want'; and, Unemotional, e.g. 'I hide my feelings from others'. Items are scored on a four-point Likert scale from Not at all true (0) to Definitely True (3) with 12 items reverse-scored. Total scores and

sub-scales are summed by adding the relevant items, with higher scores indicating stronger presence of CU traits. Internal consistency of the total score is very good ( $\alpha = .81$ ) and for the subscales is acceptable:  $\alpha_{\text{callousness}} = .66$ ;  $\alpha_{\text{uncaring}} = .72$ ; and  $\alpha_{\text{unemotional}} = .64$  (Ciucci et al., 2014). Internal consistency in the present sample was not assessed as this measure was excluded from sample analysis.

**Childhood Trauma Questionnaire-Short Form (CTQ-SF; Bernstein et al., 2003).** The CTQ-SF is a 28-item measure of experience of trauma in childhood. It has five domains: emotional abuse, e.g. 'I felt that someone in my family hated me'; emotional neglect, e.g. 'I felt loved' (reverse scored); sexual abuse, e.g. 'Someone tried to touch me in a sexual way or tried to make me touch them'; physical abuse, e.g. 'People in my family hit me so hard that it left me with bruises or marks'; and, physical neglect, e.g. 'I didn't have enough to eat'. Items are rated on a five-point Likert scale from Never True (1) to Very Often True (5), with higher scores indicating greater levels of trauma. A three-item minimization/denial scale is also included to assess for underreporting and these items are scored 1 only if endorsed as 'very often true', giving a total scale score of 3. Excellent psychometric properties have been demonstrated for the five scales:  $\alpha_{\text{emotionalabuse}} = .89$ ;  $\alpha_{\text{physicalabuse}} = .86$ ;  $\alpha_{\text{sexualabuse}} = .95$ ;  $\alpha_{\text{emotionalneglect}} = .89$ ; and  $\alpha_{\text{physicalneglect}} = .78$  (Bernstein et al., 2003). Internal consistency in the present sample was not assessed as this measure was excluded from sample analysis.

### ***Analysis***

Hierarchical multiple regression analysis was intended to be used to explore if epistemic trust and psychopathology predicted judgments of the therapeutic relationship. Correlation analysis would have been used to assess how mentalizing related to these variables, with a view to controlling for this, or including it in an exploratory moderation analysis if appropriate. Correlation analysis would also have been used to explore how the number of therapy sessions and gender related to

these other variables, so that these too may have been controlled for if found to be confounding. A separate hierarchical multiple regression analysis was planned to explore if epistemic trust and psychopathology predicted the difference in clients' presumed clinician view of the alliance and the clinicians' actual view of the alliance.

However, due to the smaller sample size only key study variables relating to epistemic trust, mentalizing, therapeutic alliance and social networks were analysed using descriptive statistics and correlational analysis. Tests for normality were planned, and it was anticipated that the scoring of the Reflective Function Questionnaire would lead to a positive skew in the data. This was to be tested and non-parametric tests used where appropriate. Due to the small n, subscales were not used, and measures of psychopathology were not included in the correlation analysis so as to limit the likelihood of a Type 1 Error. Repeated measures ANOVA was planned to test the difference in therapeutic alliance ratings between client own, client presumed clinician and clinician perspectives.

For the social network data, the intention had been to compare the young person and clinician ratings of the social network using a mixed-model ANOVA with respondent (clinician vs. client) as the between subjects variable and network type (personal vs. professional) and question (nine levels) as the within subjects variables. Multiple regression analysis would then have been used to explore how epistemic trust and psychopathology predicted any key differences that emerged from the first stage of the social network analysis. However, only six of the sixteen social network questionnaires by clinicians were completed and returned prior to data collection ceasing. As such, an exploratory approach was taken of looking at correlations of the young person's ratings in relation to the key questionnaire data so that this might inform future research in the area.

In order to learn as much as possible from the smaller sample, comparative case analysis was also carried out for the individuals who scored the highest and the lowest on the measure of epistemic trust, taking in to account mentalizing

scores, alliance ratings and social network data. The Revised Children's Anxiety and Depression Scale measure of psychopathology was included in the case analysis as raw data is converted to a t-score using tables in the published User Guide (Chorpita et al., 2015), thus allowing interpretation of a score without requiring comparison to the scores of other participants in this study. Likewise, the Strengths and Difficulties Questionnaire measure of symptomology was also included in the case analysis as scores are classified in relation to population-based UK survey data, again enabling interpretation without the need to analyse the other sample scores.

### ***Ethics***

This study was reviewed and given a favourable opinion by London - Bloomsbury Research Ethics Committee (Project ID Number): 16/LO/2108 (Appendix F).

### **Results**

Kolmogorov-Smirnov normality tests were not significant for the key questionnaire variables of Epistemic Trust Scale and therapeutic alliance and so parametric tests were used for these data. However, as predicted, there was significant deviation in the distribution of the Reflective Function Questionnaire data. For the Reflective Function Questionnaire uncertainty subscale the Kolmogorov-Smirnov test was not significant ( $p = .075$ ), but there was a substantial positive skew of 1.24 ( $SE = .56$ ) and kurtosis of 1.15 ( $SE = .56$ ). For the Reflective Function Questionnaire certainty subscale the Kolmogorov-Smirnov test was significant ( $p = .007$ ), though the positive skew of .70 ( $SE = .56$ ) and kurtosis of -.83 ( $SE = 1.09$ ) were moderate. Given these deviations, Reflective Function Questionnaire data were regarded as non-normal and Spearman's correlation coefficients were used for all correlations involving either the Reflective Function Questionnaire uncertainty subscale or Reflective Function Questionnaire certainty subscale. Pearson's correlation coefficients were used for all other correlations not involving either of

these. A one-way ANOVA comparing key questionnaire variables between the different test sites was not significant for any variable, suggesting homogeneity across sites.

Due to the small sample size, there is an increased risk of Type I Error and so moderate correlations and those with weaker statistical significance are interpreted with caution. This is particularly notable for analysis concerning clinician alliance ratings as this sample size was even smaller, with p values for all significant results close to the alpha level of .05. Furthermore, the sample is heterogeneous and though it had been planned to control for a number of potentially confounding variables in the analysis, this was not appropriate given the change in analysis and reduced sample size. As such, caution must be exercised in interpreting the results, bearing in mind factors such as number of therapy sessions, attachment style and gender.

### ***Epistemic Trust and Mentalizing***

Descriptive statistics are shown in Table 1. Epistemic trust related positively to hypomentalizing and negatively to hypermentalizing (Table 2). This suggests that higher levels of trust may be associated with greater difficulty in interpreting the mental states of others (hypomentalizing); whilst lower levels of trust are associated with a stronger tendency to over-interpret the mental states of others (hypermentalizing). However, note that the correlation between epistemic trust and hypomentalizing should be interpreted with caution as the p-value was .049 and there is an increased risk of Type I Error due to multiple correlations being conducted.

**Table 1**

*Descriptive Statistics of Key Questionnaire Variables*

Variable	n	M	SD
Epistemic Trust	16	109.94	8.77

Hypomentalizing	16	6.19	4.61
Hypermentalizing	16	4.50	2.97
Therapeutic Alliance, client perspective	16	32.81	6.01
Therapeutic Alliance, client presumed clinician perspective	16	34.31	3.46
Therapeutic Alliance, clinician perspective	12	41.75	5.56

### ***Therapeutic Alliance***

Therapeutic alliance ratings differed significantly depending on the perspective: clients' own perspective; clients' presumed clinician perspective; or, clinicians' actual perspective,  $F(2,22) = 20.38, p < .001, \eta_p^2 = .65$  (Table 1). Post-hoc Bonferroni-corrected paired-sample t-tests indicated the clinicians' ratings of the alliance differed from clients' own perspective ( $t(11) = 5.58, p < .001$ ) and clients' presumed perspective of the clinician ( $t(11) = 4.47, p = .002$ ). However, clients' ratings from their own and the presumed perspective of the clinician did not significantly differ.

Consistent with this, clinician alliance ratings were not significantly correlated with client presumed clinician ratings, and its association with clients' own alliance ratings is also unclear ( $p = .044$ ; Table 2). However, clients' own ratings and presumed clinician ratings appear positively associated. More positive alliance judgements from the clients' presumed clinician perspective were related to higher levels of epistemic trust, whilst more positive clinician views on the alliance may relate to clients' tendency to hypomentalize ( $p = .031$ ), or struggle to interpret the mental states of others. Neither clients' own alliance judgments nor clinician alliance judgments significantly correlated with epistemic trust. Client judgements from

**Table 2***Correlation Coefficients for Key Questionnaire and Social Network Variables*

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Epistemic Trust	-														
2. Hypomentalizing	.43 <sup>S*</sup>	-													
3. Hypermentalizing	-.52 <sup>S*</sup>	-.15 <sup>S</sup>	-												
4. STAR-P	.28	.18 <sup>S</sup>	.15 <sup>S</sup>	-											
5. STAR-C CYP	.60 <sup>**</sup>	-.01 <sup>S</sup>	-.10 <sup>S</sup>	.70 <sup>**</sup>	-										
6. STAR-C Clin	.06	.55 <sup>S*</sup>	.33 <sup>S</sup>	.50 <sup>*</sup>	.35	-									
7. Number of people							-								
Personal	.10	-.26 <sup>S</sup>	.09 <sup>S</sup>	-.18	.17	.40									
Professional	-.29	-.17 <sup>S</sup>	.59 <sup>S**</sup>	.04	.14	.39									
8. Frequency								-							
Personal	-.08	-.07 <sup>S</sup>	-.50 <sup>S*</sup>	.19	-.06	-.36	-.39								
Professional	.06	.01 <sup>S</sup>	-.31 <sup>S</sup>	-.52 <sup>*</sup>	-.39	-.17	-.01								
9. Approachability									-						
Personal	-.21	.01 <sup>S</sup>	-.09 <sup>S</sup>	.43 <sup>*</sup>	.21	.00	-.49 <sup>*</sup>	.40							
Professional	.03	-.22 <sup>S</sup>	.11 <sup>S</sup>	-.33	.05	-.45	.06	.35							
10. Understanding										-					
Personal	-.35	-.22 <sup>S</sup>	.09 <sup>S</sup>	-.14	-.34	-.50 <sup>*</sup>	-.19	.15	.27						
Professional	.49 <sup>*</sup>	.04 <sup>S</sup>	-.27 <sup>S</sup>	.27	.30	-.36	-.29	.13	.33						

**Table 2 Continued**

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
11. Emotional support											-				
Personal	-.20	.20 <sup>S</sup>	-.02 <sup>S</sup>	.12	-.08	.00	-.41	.22	.71**	.50*					
Professional	.44*	.27 <sup>S</sup>	-.66 <sup>S**</sup>	.44*	.53*	-.23	-.25	-.01	.05	.70**					
12. Practical support												-			
Personal	.30	.12 <sup>S</sup>	-.32 <sup>S</sup>	.57*	.41	.17	-.43	.35	.74**	.14	.59**				
Professional	.41	.22 <sup>S</sup>	-.48 <sup>S*</sup>	.19	.26	-.23	-.56*	-.22	.18	.61**	.70**				
13. Informational support													-		
Personal	-.03	-.01 <sup>S</sup>	-.23 <sup>S</sup>	.22	-.02	-.14	-.51*	.27	.53*	.44*	.66**	.67**			
Professional	.23	.38 <sup>S</sup>	-.28 <sup>S</sup>	.38	.38	.14	-.14	.02	.05	.59**	.75**	.49**			
14. Reliability														-	
Personal	.02	.07 <sup>S</sup>	-.19 <sup>S</sup>	.21	.18	.28	-.10	.33	.75**	.29	.72**	.78**	.51**		
Professional	.07	.01 <sup>S</sup>	-.25 <sup>S</sup>	.12	.31	-.10	-.11	-.17	.18	.13	.44*	.27	.56*		
15. Frustration															-
Personal	.42	.25 <sup>S</sup>	-.79 <sup>S**</sup>	.09	.09	-.18	-.41	.39	.07	-.46*	-.14	.26	-.14	-.01	
Professional	.41	.25 <sup>S</sup>	-.14 <sup>S</sup>	-.28	-.30	-.16	-.25	-.35	-.12	.05	-.26	-.02	-.47*	-.56*	
16. Trust															
Personal	-.27	-.29 <sup>S</sup>	.16 <sup>S</sup>	.05	-.13	-.03	.12	.55*	.41	.43*	.37	.37	.38	.68**	-.18
Professional	.38	-.17 <sup>S</sup>	-.25 <sup>S</sup>	.21	.55*	-.01	-.19	.02	.50*	.66**	.65**	.58**	.58**	.51*	-.34

Note. Personal = relating to personal network. Professional = relating to professional network. Number of people = number of people in network listed (up to 5). Variables 8-16 = questions 1-9 from the Social Network Analysis Questionnaire.

<sup>S</sup> signifies Spearman's correlation coefficient.

\*\* Correlation is significant at .01 level (1-tailed).

\* Correlation is significant at .05 level (1-tailed).

their own and the presumed perspective of the clinician were not significantly related to mentalizing. It is not clear how the number of therapy sessions may have affected these associations as the small sample size meant this was not included in the revised data analysis.

### ***Social Network Analysis***

Participants listed more people in their personal support network than their professional support network,  $t(15) = 4.75, p < .001$  (Table 3). Fourteen of the sixteen participants listed their mum in their personal support network, nine of whom listed their mum first. In comparison, only four participants listed their dad in their personal support network. Fourteen participants listed friends in their personal support network and the two who did not list friends listed only their parents. Every participant listed their therapist in their professional support network, ten listing them first, four listing them second and two listing them third. Eleven participants listed someone from school in their professional support network, whether form tutor, teacher or pastoral care worker.

**Table 3**

*Descriptive Statistics of Social Network Variables*

Social network variable	Personal Network		Professional Network	
	M	SD	M	SD
Number of people listed	4.06	1.34	2.50	1.21
Q1. Frequency of Contact	4.50	.44	3.60	.48
Q2. Approachability for help	3.59	.64	3.53	.64
Q3. Feeling understood	3.86	.54	3.74	.71
Q4. Emotional support	4.15	.54	4.16	.70
Q5. Practical support	3.26	.89	3.79	1.15
Q6. Informational support	3.68	.69	4.09	.62
Q7. Reliability	4.23	.47	4.23	.58
Q8. Frustration	2.60	.80	1.70	.73
Q9. Trust	4.55	.45	4.15	.60

It seems higher epistemic trust may relate to feeling more understood and emotionally supported by professionals (Table 2). Hypermentalizing, or over-interpreting the mental states of others, was related to listing more professionals, but feeling less emotionally and possibly less practically supported by them. Hypermentalizing also related to feeling less frustration in personal relationships. Hypomentalizing did not significantly relate to any social network variables. Epistemic trust and mentalizing did not significantly correlate with any of the other social network variables.

The client's view of the therapeutic alliance may relate to frequency of contact and emotional support from the professional support network. The presumed clinician view of the alliance was more clearly related to feeling emotionally supported by professionals as well as to overall trust in the professional network, though correlation between epistemic trust and overall trust in the professional network only approached significance ( $p = .075$ ).

A number of associations appear to exist between variables within the social network analysis, such as: frustration in personal support networks relating to feeling less understood, whilst in professional support networks it related to lower levels of informational support and reliability. Likewise: the single item trust question in the social network questionnaire was significantly correlated with approachability, emotional support, practical support, informational support and reliability in the professional network; but the same pattern was not seen in the personal network, where trust related to frequency of contact, understanding and reliability. These results may suggest that frustration and trust in personal and professional networks are judged on the basis of different criteria. However, due to the low power of the study it is not clear if these associations are spurious. Moreover, professional network analysis was based on a significantly smaller number of data sets due to fewer people being listed on average than in the personal networks. The original analysis plan included controlling for number of people listed, as well as testing for

the role of other variables, including psychopathology and childhood trauma in these associations. But this was not possible due to the small sample size and revised analysis plan. As such, interpretation of these patterns is restricted.

### ***Comparative case analysis***

A comparative case analysis was carried out for two young people: Young Person 1 who had the highest reported levels of epistemic trust (Epistemic Trust Scale = 136) and Young Person 2 who had the lowest reported levels of epistemic trust (Epistemic Trust Scale = 101). Young Person 1 identified with a secure attachment style and there was little discrepancy between their view of the therapeutic alliance (Scale to Assess the Therapeutic Relationship Patient Version = 34) and their presumed perspective of the clinician (Scale to Assess the Therapeutic Relationship Clinician Version completed by patient = 35). In contrast, Young Person 2 identified with an avoidant attachment style and judged their view of the therapeutic alliance to be much higher (Scale to Assess the Therapeutic Relationship Patient Version = 40) than their presumed perspective of the clinician (Scale to Assess the Therapeutic Relationship Clinician Version completed by patient = 34). This discrepancy in ratings for Young Person 2 appears higher than the average discrepancy across all those sampled ( $M = 1.50$ ,  $SD = 4.37$ ).

Hypermnetalizing scores for both Young Person 1 and Young Person 2 were within one standard deviation of the mean. However, the hypermentalizing score for Young Person 2 was more than one standard deviation higher than the mean (Young Person 2 Reflective Function Questionnaire Certainty Subscale = 9), suggesting they were more prone to making assumptions about the mental states of others, beyond the observable data. This appears consistent with the broader pattern of epistemic trust correlating negatively with hypermentalizing that was reported earlier.

With respect to psychopathology and symptomology, Young Person 1 and Young Person 2 differed in their responses on the Revised Children's Anxiety and

Depression Scale and Strengths and Difficulties Questionnaire. Young Person 1's t-scores on the Revised Children's Anxiety and Depression Scale subscales were within the normal range, with the exception of the depression subscale ( $t = 73$ ), the t-score for which suggests this is likely to be above the clinical threshold for meeting criteria for major depression, putting Young Person 1 in the top 2% of responders (Chorpita et al., 2005). Young Person 2 was also above the clinical threshold for the depression subscale ( $t = 76$ ), but additionally showed elevated levels of anxiety which were reflected in their above clinical threshold panic subscale score ( $t = 77$ ), and their borderline clinical threshold separation anxiety subscale score ( $t = 67$ ), which indicates they are in the top 7% of responders for separation anxiety (Chorpita et al., 2005). Young Person 1 and Young Person 2 scored similarly on the Strengths and Difficulties Questionnaire total symptomology score (Young Person 1 = 21 vs. Young Person 2 = 22) with both categorised as 'very high'. However, where Young Person 1 scored similarly for internalising (11) and externalising (10) difficulties, Young Person 2 scored higher on internalising difficulties (14) than externalising difficulties (8). This appears consistent with Young Person 2's elevated anxiety scores on the Revised Children's Anxiety and Depression Scale.

Young Person 1 listed five people in each of their personal and professional support networks, whilst Young Person 2 only listed three people in the personal network and two people in their professional network. This is inconsistent with predictions from the overall study analysis, which suggests hypermentalizing is associated with listing more people. As Young Person 2 showed greater hypermentalizing, it would be anticipated that they would have listed more professionals than Young Person 1 who showed less tendency to hypermentalize. Averaging across relationships, Young Person 1 and Young Person 2 rated personal and professional relationships within 1 point of each other across each domain assessed. Young Person 1 rated all domains slightly higher than Young Person 2, with the exception of: likelihood of approaching people in their personal

support network for help (Young Person 1 = 3.60 vs. Young Person 2 = 4.33); and feeling understood by people in their personal (Young Person 1 = 3.80 vs. Young Person 2 = 4.33) and professional (Young Person 1 = 3.40 vs. Young Person 2 = 3.50) support networks. It is worth noting that the slightly higher scores of Young Person 1 extended to feelings of frustration in both their personal (Young Person 1 = 2.00 vs. Young Person 2 = 1.67) and professional (Young Person 1 = 1.80 vs. Young Person 2 = 1.50) support networks.

## **Discussion**

Due to the smaller than planned sample, it has not been possible to investigate either the hypotheses regarding the predictive nature of the questionnaire variables, nor the potential role of psychopathology in the reported effects. It has also not been possible to provide a full analysis of the social network constructs and how these relate to wider questionnaire variables. However, it has been possible to provide a preliminary and simple exploration of the way in which therapeutic alliance ratings relate to epistemic trust, mentalizing and social networks. These findings are reported and interpreted cautiously in the context of a heterogeneous sample, where numerous variables could not be included in the analysis to address the heterogeneity due to the lack of statistical power. They are also interpreted with full awareness of the high risk of both Type I and Type II errors. It is hoped these preliminary results will provide useful learning for future research in this area, and that such research will be able to take a broader and more nuanced view of the patterns reported here.

As predicted, there was some evidence that therapeutic alliance ratings differ depending on the rater and which key questionnaire and network variables the ratings were associated with. For example: client alliance ratings were related to feeling more emotionally supported by professionals, which is consistent with research showing client alliance ratings are influenced by clinician sensitivity to emotional concerns and provision of emotional support (Pinto et al., 2012).

Furthermore, the findings indicated that emotional support from professionals also related to client presumed clinician judgments, suggesting a connection between how emotionally supported the client feels and how they imagine the clinician views the therapeutic relationship. Mentalizing is harder when emotionally aroused (Fonagy & Luyten, 2009) so it is possible that clients find it easier to mentalize a positive therapist alliance view when feeling better emotionally supported.

It may be interesting to contrast this pattern with clinicians' alliance views. The literature suggests that client and clinician alliance judgments are made on the basis of different criteria and that clinician judgments may not reflect such dependency on emotional support (Bachelor, 2013; Heinonen et al., 2014; Holdsworth et al., 2014). Here, clinician ratings were not associated with emotional support or indeed any of the key questionnaire or social network variables. However, as this may reflect a Type II error due to the particularly small sample size ( $n = 12$ ), this will not be considered further. So, the current data cannot be used to elaborate these speculations but they do point to the potential of further research to explore if and how clinician judgments relate to emotional support. Through better understanding of how clients or clinicians arrive at respective judgments of the therapeutic relationship, we may come to a better appreciation of the observed differences in their predictive value (Shirk et al., 2011).

Perhaps the most notable finding of the present investigation is that only presumed clinician alliance judgments were related to epistemic trust and overall trust in professional networks: higher trust correlated with higher presumed (imagined) alliance judgments. Development of epistemic trust is contingent on evaluating the authenticity of information shared, but also the authenticity of the person communicating the information (Fonagy et al., 2015), with judgments of the latter considered less cognitively demanding and consequently utilised more readily as a shortcut (Sperber, 2001). In the therapeutic relationship this means the client must view the clinician as appropriately motivated and trustworthy in order to feel

safe enough to learn from that individual and internalize that learning to guide change (Fonagy & Allison, 2014). The current findings suggest it is possible for a client to have the capacity to trust but this does not mean that they will construe the clinician as trustworthy. What the clinician needs to do to achieve a change in this presumption is a potential subject for future investigations.

However, in the current context this pattern of findings may help explain the aforementioned relationship between mentalized clinician alliance ratings and emotional support, as epistemic trust was positively correlated with both. Theoretically there could be several ways in which this association may play out: epistemic trust facilitates positive presumed alliance views, which enables the client to feel emotionally supported and benefit from the help offered (Bevington, in press.); or, feeling emotionally supported enables a positive imagined alliance view, which opens the potential for meaningful exchange of social information via the privileged route for social learning protected by natural selection (Csibra & Gergely, 2009) what Fonagy & Allison, (2014) term 'an epistemic superhighway'. This needs to be explored in larger studies using analysis that can consider the unique variance accounted for by each of these factors and the directionality, or possible circularity, of this influence.

It is important to consider the related concepts of attachment and mentalizing in alliance judgments. Though attachment style was not analysed for the sample as a whole, the Case Analysis offers a perspective on the role of attachment in alliance ratings. Children with an avoidant attachment style report greater perceived rejection from both their mothers and fathers (Muris et al., 2000). The propensity to perceive rejection may help us to understand the discrepancy in own and imagined views of the therapeutic relationship seen in the comparative case analysis for YP2 who had an avoidant attachment style, but not YP1, who had a secure attachment style. YP2's ratings may be seen to suggest that although they felt they had a good relationship with the therapist, they anticipated the therapist would, in a rejecting

fashion, rate the relationship less highly. This is consistent with YP2 showing higher levels of anxiety, most notably separation anxiety and the lowest recorded levels of epistemic trust, both of which are developmentally related to attachment style (Fonagy, Campbell, et al., 2017; Fonagy & Luyten, 2018a).

This is also consistent with YP2's elevated tendency to hypermentalize. Over-interpretation of others' behaviour is associated with disrupted attachment and lower levels of epistemic trust (Bo et al., 2017; Fonagy et al., 2015), both of which characterise YP2. Indeed, hypermentalizing was associated with lower epistemic trust levels when considering the sample as a whole. It was hypothesised that a tendency to negatively mis-interpret others would relate to more negative assumptions about the therapist's perception of the relationship. Thus, it is perhaps surprising that mentalizing was not directly related to clients' presumed clinician view of the relationship in the overall sample. There are several possible explanations for this, including most importantly of course, Type II error and the limited scope of the measures of mentalizing included in the current design. However, it is possible that the client's presumed clinician alliance judgments do not reflect mentalizing abilities because low mentalizing may lead a person to predict a good relationship when in fact the presumption is ill-grounded or high mentalizing may help a person identify potential subtle problems in the therapeutic relationship. Further, it is possible that a relationship exists between mentalizing and presumed alliance but this may be indirect, perhaps partially moderated by epistemic trust: a better capacity to mentalize leads clients to predict stronger alliance on the part of the clinician but only once trust is established. Future research should explore these possibilities, for instance by increasing statistical power or by including an alternative measure of mentalizing that captures the full range of mentalizing abilities, not just mentalizing problems as the RFQ does.

Though preliminary, these results have clinical implications for engaging with clients' attempts to mentalize clinicians' views of them. In his book *The Gift of*

Therapy (2002), Irvin Yalom describes the importance of noticing if a client makes suppositions about how the clinician feels and if these tend to err in one direction, such as caring less for the client or finding the client frustrating. Yalom sees this as an opportunity for teaching the client empathy which will benefit their interpersonal life. This may also be about engaging with attempts to mentalize, something regarded as an important generic and transdiagnostic component of therapy (Fonagy & Allison, 2014). These results suggest attempts to mentalize the therapists' views of the alliance may have particular implications for the interrelated concepts of epistemic trust, trust in professional networks and sense of emotional support from professionals.

Such attempts may provide insight to client views and possible routes to cultivate change, for instance: engaging with client attempts to mentalize the therapist, using this as an opportunity to engage the client's mentalizing capacity and introducing flexibility of different perspectives. In doing this, the aim is for the client to regain some of their mentalizing capacity, and to feel mentalized or understood themselves. As discussed earlier, this experience of feeling understood is a good way to cultivate epistemic trust and open the client up to learning within the therapeutic relationship (Fonagy & Allison, 2014). Therapists might also focus on development of epistemic trust through the use of alternate ostensive cues, that help the client understand the intention and personal nature of the therapist's communication. Future research is required to consider how the ability to mentalize therapists' views of the alliance varies with these interrelated concepts over the course of therapy so as to better understand how this might be changed, and how this may impact the predictive value of alliance ratings of treatment outcomes and engagement.

There are several limitations to the study. First, the sample size is very small. This means the study has low power, and there is a greater chance of a Type II error. Though the analytic plan was changed to try and reduce this, the changes

implemented brought an increased risk in Type I error due to the number of correlation analyses conducted. To address this required several variables to be excluded from further analysis, most notably all measures of psychopathology. As such, it is not possible to comment on how patterns of psychopathology or early childhood trauma may relate to the effects described here as the study design called for and so the picture presented is incomplete, leading to poorly grounded assumptions of homogeneity in drawing interpretations from a heterogeneous sample.

Second, there is potential for sampling bias to have occurred due to the way in which participants were recruited via referral by their clinician. This approach was dictated by the necessity of clinician involvement in the study. However, it meant that recruitment was subject to selection bias by the clinician, depending on how willing they were to discuss the study with clients, and which of those on their case load they felt it appropriate to invite to such discussions. Clinicians were aware of the broad focus of the study and it is possible they were disinclined to refer clients with whom they felt they had a less positive relationship, perhaps reflective of the overall high therapist alliance ratings observed and the relatively low variance in alliance. As such, future studies should seek to utilise alternative recruitment approaches in order to ensure diversity in the sample.

Third, the study utilised a cross-sectional design and thus did not capture a sense of how these dynamic constructs may have changed over the course of therapy. Owing to the recruitment strategy, the participants had received varying numbers of therapy sessions prior to taking part, and thus it was not possible to ascertain how stage of therapy may have impacted the associations captured here. Future research may rectify this but using a longitudinal design to capture development of these constructs across the course of therapy. In so doing, greater insight may be gained regarding the way in which different variables may facilitate or hinder development in other areas.

Fourth, this study utilised only self-report measures. As discussed in Chapter 1 of this thesis, there are several limitations to self-report questionnaires. Van de Mortel's (2005) review of self-report measures raised a number of concerns around participants' desire to present a favourable image of oneself. It was suggested that they may be aware of their tendency to give socially desirable responses ('faking good') or they may believe what they report (self-deception), but that either way this would influence the quality of the data collected. The notion of subjectivity has been central to the research questions of this thesis and where possible self-report measures were selected for having been appropriately validated against other objective measures. Nonetheless, future research in this field must seek to compare and validate this approach by seeking objective concordance of key measures and by utilising a greater range of assessment approaches, such as observer ratings of attachment or computerised mentalizing tasks.

Finally, there is an argument for considering "active mind-mindedness that extends well beyond the dyad of patient and therapist and out into our own social connectivity" (Bevington, in press.). That is, consideration of how therapists interact and engage with members of the clients' network, represented by alter-alter ties in SNA. Bronfenbrenner's ecological systems theory (1989) suggests that these connections may indirectly have a significant impact on children's lives and should thus be considered. This study offered a feasibility assessment of such investigations, and for such alter-alter explorations to work, it is likely that they would need to be carried out on a more targeted group.

## **Conclusions**

Poor epistemic trust is suggested to contribute to poor therapeutic engagement and outcome (Fonagy et al., 2015). This was explored using a novel method to better understand the role of how clients perceive clinician engagement and motivation. These preliminary findings are broadly congruous with the epistemic trust literature and suggest that epistemic mistrust may relate to how clients think

the clinician views them and may reflect a tendency to hypermentalize. This has potential clinical implications, offering support for the importance of noticing and responding to attempts to mentalize the therapist, and using these as an opportunity to cultivate trust. These findings were considered in the context of the broader social network, and there is preliminary evidence that differences in epistemic trust, mentalizing and therapeutic alliance are also reflected in broader social network engagement, particularly in relation to perceived emotional support. Analysis was simplified due to the small sample size, but these preliminary findings suggest future research is warranted to better understand factors related to engagement.

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### **Part 3: Critical Appraisal**

## **Introduction**

This critical appraisal sets out reflections on the challenges of conducting the research presented in the empirical paper and the potential for future research to explore temporal changes in the alliance in relation to epistemic trust. Consideration is given to the role of psychopathology, which could not be investigated here due to sample size. Reflections are offered on how the research has impacted me as a researcher and a clinician, with special attention given to the impact of the COVID-19 global pandemic and my current clinical placement.

## **Recruitment: challenges and strategy**

The NHS Long Term Plan (NHS England, 2019) states research and innovation are imperative in driving outcomes and future improvement. It speaks of recognising the impact of clinical research and a plan for increasing service user recruitment. Yet, at a service-level, research may be less present and, in my experience, possibly less welcome depending on its nature. Having successfully navigated NHS REC approval, HRA approval and finally R&D approval in multiple sites, I was surprised by the reluctance of some managers and clinicians to share this study with their clients.

It would be a great disservice to those who went above and beyond to facilitate recruitment to the project to suggest this attitude was universal. It wasn't. There were numerous kind and helpful people who aided the recruitment and it is thanks to them that we were on track to recruit the required forty participants. However, there were also several who were opposed to it: expressing concern about asking clients to fill in questionnaires about potentially emotive topics; and, fearing what participation would do to the therapeutic alliance. There was a sense that talking about the alliance might threaten it. I found this hard to swallow given my own clinical experience and the mass of research to the contrary (Bordin, 1994; Foreman & Marmar, 1985; Gaston et al., 1991). What is more, it was not that young people were declining to take part, but rather that their clinicians were deciding, on

the basis of unknown criteria, to not speak to them about it. It seemed unfair that young people were denied the opportunity to take part and to receive a £20 voucher. This felt relevant to all ages, but particularly the older adolescents who were themselves able to consent to taking part. In doing this, young people were denied agency, which seems ironic given the therapeutic process is about young people gaining agency.

The recruitment strategy was outlined in the NHS REC and HRA documents as this was felt to be necessary due to the clinician being required to complete certain measures. However, it may not be fit for purpose as a strategy due to the inequalities and biases it potentially propagates. Why is it that certain clinicians felt more able to speak to clients about this? Could it be somehow reflective of their theoretical orientation, their competence or confidence as a clinician or perhaps their stage of career? Why is it that these clinicians approached certain people on their case load and not others? Were the clients they approached deemed more able or amenable or reliable? All of these questions raise the idea of sampling bias and this may have impacted the research reported here. It will be important for future research to consider a new recruitment strategy that can help ameliorate some of these potential biases.

### **Temporal Changes**

The research reported here and elsewhere (Horvath & Symonds, 1991; Shirk & Karver, 2003) tells me that my sense of the therapeutic relationship is likely not to be a good gauge of what the young person thinks of our alliance, and in turn what outcomes we can expect from the therapy. However, I am curious if this is limited to the absolute value of alliance judgments, or if it also extends to perceptions of change in the alliance over time. In my clinical experience, I believe that I have observed changes over time, for instance: in what clients bring to our sessions, perhaps sharing a response to a question I asked several weeks previously that was met with no answer; in presentation and engagement; and, in explicitly elicited

feedback on the alliance and the sessions. So, I find myself asking am I picking up on changes in the alliance and how may these relate to epistemic trust?

Temporal changes in therapeutic alliance (Labouliere et al., 2017), epistemic trust (Fonagy & Luyten, 2016) and mentalizing (Fonagy & Allison, 2014) are well established theoretically, as is the way in which these processes may shape each other. But, as of yet, there has been no empirical test of the dynamic entwined developmental nature of these concepts. The research in the empirical paper took a single time-point snapshot of how the concepts relate. This was useful as it provided us with a basis from which to consider the broad concepts and the methods used to test them. To further understand this, future research should consider using growth models to track changes in these process variables over the course of therapy. Growth models measuring changes in epistemic trust, mentalizing and therapeutic alliance will allow us to ask questions about the causality of these patterns. Drawing on the literature and the preliminary results reported here, it has been hypothesised that epistemic trust may moderate the relationship between mentalizing and therapeutic alliance. A growth model should be used to test if development of mentalizing across therapy does indeed lead to improved alliance provided epistemic trust is established.

Moreover, future research can consider how this relates to psychopathology and the influence this may have on the nature and trajectory of these changes. Psychopathology was excluded from the group analysis in the empirical paper in a bid to reduce Type II Error due to the small sample size. This was frustrating as the literature and the Case Analysis suggest there is a role for psychopathology in our understanding of these concepts and patterns. Whether this effect occurs through influence on mentalizing and epistemic trust alone or in conjunction with other factors should be considered and so it would be important for growth model analysis to include measures of symptomology across therapy. For instance, it may be hypothesised that those with presentations associated with epistemic mistrust and

mentalizing failures would initially be slower to show changes in alliance, suggesting the relationship is not linear. Instead, you may predict presentations like BPD to be characterised by increasing incremental changes as the mutually reinforcing benefit of epistemic trust on mentalizing and alliance are realised. In other words, the progress in therapeutic alliance might appear slow initially but show step changes once momentum builds.

This hypothesis may reflect broader growth patterns for models of therapeutic change. Baldwin and colleagues (2009) compared: dose-effect models, where the therapeutic change is seen as negatively accelerating and patients are presumed to change at the same rate, despite total number of sessions; and, good-enough level models, where it is assumed that patients will change at a different rate depending on the number of sessions that they have. In the latter, the length of treatment is seen to reflect how malleable patients' symptoms are, with patients receiving lower doses of treatment being those who change rapidly and those receiving higher doses being those who change slowly. The results supported the good-enough level model, and Baldwin et al (2009) highlight that some patients will require longer treatment to adequately serve their needs. They argue that to fully understand the clinical implications of this finding, further research is required to explore the patient, therapist, treatment and contextual factors that affect treatment response.

I propose that epistemic trust be considered as one of these factors. Fonagy and colleagues have suggested we “see the destruction of trust in social knowledge as the key mechanism in pathological personality development” (Fonagy et al., 2015, p. 589). If individuals require more time to establish epistemic trust with a therapist, it may reasonably be argued that they require more time before they can benefit from the therapy. Clinically this implies that in time-limited models additional early sessions should be offered to build trust. Much like the systemic notion of ‘talking about talking’, this could set the scene for therapy, helping to stack the odds in favour of those whose early experiences have stacked them the other way. This

feels particularly relevant to service design in the context of an increasing trend towards time-limited models, and future research would do well to consider the role of epistemic trust in this variability in speed of change. In doing so, we may better understand why one in four young people with a diagnosable mental health issue does not access treatment at all and why of those who do, one in eight find specialist mental health support unhelpful (NHS Digital, 2018).

### **Connection in a time of COVID**

The writing of the empirical paper ran parallel with the unfolding of COVID-19 and the impact that this has had on our way of life. Perhaps this is why the opening of the paper, considering the mental and physical health implications of social interaction, felt so pertinent. It had been my plan to begin in this way so as to contextualise the importance of the research and the real implications of these concepts. But, opening in that way during a time of global pandemic, when we were ordered to stay home, to try and connect with friends and family via digital platforms alone seemed relevant. There is no doubt that we will have to adapt to the 'new normal' and re-evaluate our living and working practices. But, what does this mean for mental health and for therapy?

Hailed as the 'black swan' of mental health (Wind et al., 2020), COVID-19 has seen community mental health services move to remote, often video-based, delivery of assessment and treatment. For some this is a positive, providing an opportunity to "accelerate and bend the curve on digital health" (Torous et al., 2020), offering a means for delivering therapy that is seen as more scalable and more able to meet growing demand. The current 'face-to-face' system lacks parity of access and care, in regard to ethnicity, socio-economic status, age, ability, gender, sexual-orientation and several other individual and group factors (Muntaner et al., 2000, 2007). Telehealth may offer a way to address some of these systemic failings. Few would disagree with this objective and indeed it aligns with NHS England strategies on enabling greater access to mental health services (NHS England, 2019).

On the other-hand, telehealth risks entrenching systemic failings by developing a system that for many will be even harder to access and engage in. Take for instance, the assumption that at home you have a safe, private space to speak. For many this will not be true. Consider those subjected to abuse by a person with whom they live, or those who do not feel safe from being interrupted or overheard. How will they engage? Telehealth also hinges on the assumption that people will have the money to pay for the WIFI or mobile data to enable the call and to buy the smart phone, computer or tablet to make it. Again, for many this will not be true. Those with a low socio-economic status are already more likely to experience stress associated with mental health issues and to be less likely to access support services (Muntaner et al., 2007). This risks being compounded if there is no feasible way for them to attend therapy.

Relevant to this thesis is the effect on the very nature of the communication on which therapy hinges. For example, consider the use of ostensive cues. The literature review in Chapter 1 sets out clearly how important these cues are for communication, for the development of epistemic trust, and for establishing secure attachment (Csibra & Gergely, 2009; Fonagy & Allison, 2014). Fonagy and Allison (2014) highlight the role of ostensive cueing in a therapeutic relationship, enabling a therapist to signal the relevance of information and a desire to understand the client. Much of this may be lost in an alliance established exclusively via remote methods. How can eye contact be meaningfully used when you are continually forced to choose between looking into a camera, at a video of a therapist or at a video of yourself?

Research considering the effectiveness of therapy delivered by telephone suggests that some of these concerns are unwarranted, with a recent review finding there is no difference in outcome when therapy is delivered face-to-face or via phone (Irvine et al., 2020). However, the impact of this conclusion depends on the question: who was receiving the therapy? In the review by Irvine and colleagues

(2020) studies were included where individuals presented with sub-threshold mental health difficulties and a number of them were based on university students or on the use of employee counselling helplines. It may be argued that these studies focus on groups who are already predisposed to show good engagement in therapy due to experiencing relatively mild-moderate difficulties and voluntarily engaging in support. But, what about those for whom engaging in therapy is already a challenge? The so-called 'hard-to-reach' adolescents discussed in much of this thesis may seem even harder to reach remotely, particularly when the environmental and interpersonal factors discussed above are taken into consideration.

What concerns me is that as we come to better understand the importance of factors such as epistemic trust and mentalizing in cultivating an alliance that facilitates positive outcomes, we may simultaneously move to a system that provides less opportunity for this to be done. Of course, we must adapt. There are already community psychology services that focus on engaging otherwise marginalised groups, and their work is invaluable. But, as we re-shape service delivery in a 'post COVID-19 world', should we not strive to find space for this engagement in all services? As with the possibility of additional sessions being required for early engagement, future service planning will need to very carefully consider how service delivery is designed with principles of engagement in mind. If not, we may see the disparity in treatment outcomes widen and we will have found a new way to fail those who need the most support: perpetuating the notion of the 'hard to reach client' when a 'hard to reach service' may be more accurate (Bucci et al., 2019).

### **Clinical Experience**

My clinical placements have brought to life the theory discussed here and as I move between placement days and research days, the ideas of alliance, mentalizing and trust feel like the constants I carry with me. Currently I am working in an adolescent psychiatric intensive care unit for young people with severe and complex

mental health issues, such as first episode psychosis, suicidal behaviour or severe eating disorder. There is no set length of admission and stays vary from a couple of days to over a year depending on when it is felt safe enough for the young person to be cared for in the community. Fluctuation in presentation and variability in length of stay means you do not know how many psychology sessions will be possible before the young person is discharged. This creates uncertainty, which shapes the clinical work and places an emphasis on engagement, containment and the cultivation of trust. The hope is that by giving someone a good experience of therapy, they are willing and able to engage in longer-term work in the community.

This clinical approach has felt so intertwined with the ideas and concepts explored in this thesis. I have felt grateful for the understanding I have gained through this research in orientating me to the field, and witnessing this in clinical settings has reinforced my motivation to pursue the research objectives. An appreciation for the importance of epistemic trust and mentalizing in therapeutic alliances with adolescents has helped me hold on to my curiosity, even in the moments when there is a desire to take something at face value. For instance, it may be tempting to see a sudden change in medication compliance as a positive, but not if this is a temporary shift in pursuit of discharge or a desire not to disappoint, as opposed to a genuine change of view on the role of medication. I have found myself wondering with clients about these changes, and by acknowledging that we can hold differing views in mind I have felt a shift in our mutual understanding.

As I approach the end of my clinical training, I find myself reflecting on the teaching that we have had, and that which we have not had. In my (certainly biased) view, I am surprised we have not had teaching on mentalizing as a central therapeutic tool. Early in the first-year teaching block we think about engagement, how to be and sit with clients, what we need to offer to help establish an alliance, how to formulate and contextually understand someone. Perhaps the notion of

mentalizing was implicit in there: a desire to cognise someone's perspective and to see their actions as intentional and goal orientated. But I think it would be helpful for this to be explicitly named, discussed and practiced as the pan-theoretical skill that it is. Placement contexts and theoretical orientations vary across training and trainees, but desire to engage is universal.

## **Conclusions**

In summary, the research presented in the empirical chapter feels like an important early step in exploring the role of epistemic trust in adolescent therapeutic alliances. Unfortunately, it was not possible to fully explore some of the intended concepts due to sample size limitations resulting from the COVID-19 lockdown. However, this has allowed a chance to reflect on where the research is at and consider if and how it proceeds. Problems with recruitment strategy were discussed, as was the role of future growth change modelling in order to better understand the inter-related development of epistemic trust, mentalizing and therapeutic alliance. These areas have been reflected on in relation to the current context of the global pandemic and my current clinical placement. As we consider if the remote delivery of mental health care is here to stay, I have thought about how the current research may affect its design and implementation. At its best, this is an opportunity to make the system accessible to those for whom this was not possible. At its worst, we may blindly reinforce biases, and find new ways to position support beyond the reach of many who need it. Though much has already been written, there is undoubtedly more to learn and consider about moving to telehealth, and I would argue that in doing this epistemic trust and engagement must be held in mind.

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## Appendix A

Example Participant Information Sheet for 16-18 year-olds



### Epistemic Trust and Help Networks in Adolescence

#### INFORMATION FOR YOUNG PEOPLE

##### **Invitation and brief summary**

We would like to invite you to join a research project. We want to learn more about how teenagers view their help network and the way mood affects this. We are specifically looking at epistemic trust, which means an openness to learn from others. We are looking at how trust influences young people's expectations of helping relationships. We are also interested in how young people's mood and experiences early in childhood may influence their expectations of these helping relationships. This is important to us because the information that we get from this project might help us understand factors affecting young people's engagement with help networks and may allow us to better help people in the future.

This project is being carried out by researchers at University College London (UCL). The service you attend is supporting the research project by inviting young people who attend the service to participate.

##### **What would taking part involve?**

We will meet you at the service. We will ask you to sign a form that shows you have agreed to take part and fill in some questionnaires. We will then ask your clinician to fill in some questionnaires as well, one of which is based on what you tell us about who you think is important in your helping network. Each of these things are described below.

- **The form**

The consent form shows that you agree to take part in the study.

- **The questionnaires you fill in**

There are questions about:

- Your behaviour and how you are feeling

- How you get on with friends and family
- Your expectations of helping relationships
- The people around who help you

The questionnaires we will ask you to complete are the Strength and Difficulties Questionnaire, Revised Childhood Anxiety and Depression Questionnaire, Reflective Functioning Questionnaire for Youth, Attachment Questionnaire for Children, Antisocial Beliefs and Attitudes Scale, Scale to Assess Therapeutic Relationship, Social Network Analysis Questionnaire.

- **The questionnaires your key worker fills in**

There are questions about:

- The key worker's view of your helping relationships

The questionnaires we will ask your key worker to complete are the Scale to Assess the Therapeutic Relationship and Social Network Analysis Questionnaire.

Some people prefer to fill these out themselves and other people prefer them read to them, either way we will be pleased to help you with any difficulties in answering or understanding the questions.

It is important to note that this is **NOT** a test.

All this should take around 1 hour (with breaks). If you decide that you want to stop before all the different tasks are finished then you can.

We would like to show you our appreciation for agreeing to complete the computer task, questionnaires and activities by offering you a £20 Love2Shop voucher for completing the tasks. This voucher is valid at most major high-street shops.

**What are the possible benefits of taking part?**

If you do decide to participate you will be helping us to understand the part trust plays in helping relationships. This may help other people in the future. You may also find some of the tasks enjoyable to complete.

**Are there any risks to you if you take part in the research?**

The research is not intended to be upsetting. However, if you do find it stressful or are upset by it we will provide you with information on who you can contact for support. You can also stop participating at any point during the research.

**Rules that we must follow**

There are a few things for you to know before you decide whether or not to take part in this study. We have to follow some important rules to make sure that people who help us are treated well and are safe. Here are those rules:

**(1) Consent or agreeing to take part in the study**

- You do not have to agree to take part if you do not want to. You are completely free to decide whether or not you want to take part in the study.
- **If you do agree to take part, you can change your mind and stop at any time, without giving a reason. This will result in no negative consequences and it will not affect any support you are receiving.**

**(2) Confidentiality: keeping what you tell us private**

- You should know that all the information you give is private. Nothing you say will be told to anyone outside the research team, except in three circumstances:
  - You tell us that you or another person are planning to seriously harm a specific person.
  - You tell us that you or another young person is at risk of harm.
  - We may inform your mental health worker if we are concerned about your mental health.

If it was necessary to take any of the above steps, this will be discussed with you first.

**Further supporting information**

**How will my information be kept confidential?**

All the information that you provide (from the questionnaires and computer games) will be treated confidentially. You will be assigned an ID number (e.g. 001) and we won't identify you by name to anyone. As part of the study you will be asked to list up to 10 important people in your helping network. We will share these names with your key worker, so that we can ask them about their views on this. Aside from this one exception, the information will not be shared with anyone (e.g. school). The information you give us will be used solely for this project. Once the project is finished we will happily give you a report of our findings if you are interested.

**What will happen to the results of the study?**

The report will be written about the results of the study. In that report, the results will be presented in a way that no one can find out that it is you or know that you took part. In other words, we can guarantee that information about you will be secret and private because we talk about groups not the individual.

**Who has reviewed the study?**

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by London - Bloomsbury Ethics Research Ethics Committee (Project ID Number): 16/LO/2108.

**How have young people been involved in this study?**

Young people have provided consultation to the research project by reviewing materials, planning how to present the questionnaires to young people and making adaptations to the questionnaire pack.

### **Who is organising and funding the study?**

Doctoral trainees at the Department of Clinical, Educational and Health Psychology at University College London have set up the project. Professor Peter Fonagy and Dr Tobias Nolte are supervising the research. The research is being funded by University College London and is an educational project.

### **What if something goes wrong?**

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If you have any concerns and would like to contact someone outside the team you can do this through the Research Governance Sponsor, University College London (UCL). You can write to Joint UCLH/UCL Biomedical Research Unit, R&D Directorate (Maple House), Rosenheim Wing, Ground Floor, 25 Grafton Way, London, WC1E 5DB quoting reference 16/0021. All communication will be dealt with in strict confidence.

If in the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against University College London (UCL).

**Thank you for reading ☺**

**We will contact you shortly to answer any questions and discuss whether this is a project that you would like to join.**

### **Our contact details are**

Georgina Aisbitt is the researcher on the project. If you have any questions about the project you can contact her on: [g.aisbitt.17@ucl.ac.uk](mailto:g.aisbitt.17@ucl.ac.uk)

Dr Tobias Nolte is a supervisor on the project. If you have any concerns you wish to discuss, you can contact him on: [t.nolte@ucl.ac.uk](mailto:t.nolte@ucl.ac.uk)

## Appendix B

### Example Participant Consent Form for 16-18 year-olds



Centre Number:

Study Number:

Participant Identification Number for this trial:

### CONSENT FORM

Title of Project: **Epistemic Trust and Help Networks in Adolescence**

Name of Researcher: Georgina Aisbitt

Please initial

1. I confirm that I have read the information sheet dated 22/03/2019 (version V4.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
3. I understand that some documents from the study may be looked at by responsible people appointed by UCL, who must make sure (as Research Governance sponsor) that the study is being run properly. I give permission for this group to have access to the necessary information.
4. I understand that information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1988.
5. I understand that the information collected about me may be used to support other research in the future, and may be shared anonymously with other researchers.
6. I agree that the research project named above can request information from my clinical records held at the support service that referred me to this research project.

7. I agree that someone from the research study can contact me in the future.

8. I agree to take part in the above study.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of Participant

Date

Signature

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of Person  
taking consent

Date

Signature

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**Our contact details are**

Georgina Aisbitt is the researcher on the project. If you have any questions about the project you can contact her on: [g.aisbitt.17@ucl.ac.uk](mailto:g.aisbitt.17@ucl.ac.uk)

Dr Tobias Nolte is a supervisor on the project. If you have any concerns you wish to discuss, you can contact him on: [t.nolte@ucl.ac.uk](mailto:t.nolte@ucl.ac.uk)

## Appendix C

### Epistemic Trust Questionnaire (unpublished)

Page 1 of 4

## Epistemic Trust Scale

Record ID: \_\_\_\_\_

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**Please read the following statements and indicate the extent to which you agree or disagree by ticking the box that most closely corresponds to your opinion.**

- |                                                                    |                                                                                                                                                                                                                                                                                        |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Psychotherapists are more trustworthy than most other people.   | <input type="radio"/> Strongly agree<br><input type="radio"/> Agree<br><input type="radio"/> Somewhat agree<br><input type="radio"/> Neither agree or disagree<br><input type="radio"/> Somewhat disagree<br><input type="radio"/> Disagree<br><input type="radio"/> Strongly disagree |
| 2. I would be very likely to take the advice of a psychotherapist. | <input type="radio"/> Strongly agree<br><input type="radio"/> Agree<br><input type="radio"/> Somewhat agree<br><input type="radio"/> Neither agree or disagree<br><input type="radio"/> Somewhat disagree<br><input type="radio"/> Disagree<br><input type="radio"/> Strongly disagree |
| 3. I think that my psychotherapist would always be honest with me. | <input type="radio"/> Strongly agree<br><input type="radio"/> Agree<br><input type="radio"/> Somewhat agree<br><input type="radio"/> Neither agree or disagree<br><input type="radio"/> Somewhat disagree<br><input type="radio"/> Disagree<br><input type="radio"/> Strongly disagree |
| 4. A lot of psychotherapists cannot be trusted.                    | <input type="radio"/> Strongly agree<br><input type="radio"/> Agree<br><input type="radio"/> Somewhat agree<br><input type="radio"/> Neither agree or disagree<br><input type="radio"/> Somewhat disagree<br><input type="radio"/> Disagree<br><input type="radio"/> Strongly disagree |
| 5. Most psychotherapists want what is best for their clients.      | <input type="radio"/> Strongly agree<br><input type="radio"/> Agree<br><input type="radio"/> Somewhat agree<br><input type="radio"/> Neither agree or disagree<br><input type="radio"/> Somewhat disagree<br><input type="radio"/> Disagree<br><input type="radio"/> Strongly disagree |
| 6. Psychotherapists often 'get it wrong'.                          | <input type="radio"/> Strongly agree<br><input type="radio"/> Agree<br><input type="radio"/> Somewhat agree<br><input type="radio"/> Neither agree or disagree<br><input type="radio"/> Somewhat disagree<br><input type="radio"/> Disagree<br><input type="radio"/> Strongly disagree |

7. I don't expect my psychotherapist to really care about me.
- Strongly agree  
 Agree  
 Somewhat agree  
 Neither agree or disagree  
 Somewhat disagree  
 Disagree  
 Strongly disagree
8. It will take a long time for me to trust my psychotherapist fully.
- Strongly agree  
 Agree  
 Somewhat agree  
 Neither agree or disagree  
 Somewhat disagree  
 Disagree  
 Strongly disagree
9. If I am totally open with my psychotherapist I may get hurt.
- Strongly agree  
 Agree  
 Somewhat agree  
 Neither agree or disagree  
 Somewhat disagree  
 Disagree  
 Strongly disagree
10. I don't expect my psychotherapist to tell me what he or she really thinks about me.
- Strongly agree  
 Agree  
 Somewhat agree  
 Neither agree or disagree  
 Somewhat disagree  
 Disagree  
 Strongly disagree
11. I don't think I could ever fully trust my psychotherapist.
- Strongly agree  
 Agree  
 Somewhat agree  
 Neither agree or disagree  
 Somewhat disagree  
 Disagree  
 Strongly disagree
12. I believe that most psychotherapists are sincere.
- Strongly agree  
 Agree  
 Somewhat agree  
 Neither agree or disagree  
 Somewhat disagree  
 Disagree  
 Strongly disagree
13. I tend not to follow other people's advice about how to live my life.
- Strongly agree  
 Agree  
 Somewhat agree  
 Neither agree or disagree  
 Somewhat disagree  
 Disagree  
 Strongly disagree
14. I don't like people noticing things about me that I am not aware of myself.
- Strongly agree  
 Agree  
 Somewhat agree  
 Neither agree or disagree  
 Somewhat disagree  
 Disagree  
 Strongly disagree

15. I love learning from new people.
- Strongly agree
  - Agree
  - Somewhat agree
  - Neither agree or disagree
  - Somewhat disagree
  - Disagree
  - Strongly disagree
16. Most people misunderstand me ('get me all wrong').
- Strongly agree
  - Agree
  - Somewhat agree
  - Neither agree or disagree
  - Somewhat disagree
  - Disagree
  - Strongly disagree
17. I always give people the benefit of the doubt.
- Strongly agree
  - Agree
  - Somewhat agree
  - Neither agree or disagree
  - Somewhat disagree
  - Disagree
  - Strongly disagree
18. I usually ask people for advice when I have a personal problem.
- Strongly agree
  - Agree
  - Somewhat agree
  - Neither agree or disagree
  - Somewhat disagree
  - Disagree
  - Strongly disagree
19. I don't doubt people's motives when they criticise me.
- Strongly agree
  - Agree
  - Somewhat agree
  - Neither agree or disagree
  - Somewhat disagree
  - Disagree
  - Strongly disagree
20. If you put a lot of faith in people you will get hurt.
- Strongly agree
  - Agree
  - Somewhat agree
  - Neither agree or disagree
  - Somewhat disagree
  - Disagree
  - Strongly disagree
21. I will not trust someone until they have proven themselves trustworthy.
- Strongly agree
  - Agree
  - Somewhat agree
  - Neither agree or disagree
  - Somewhat disagree
  - Disagree
  - Strongly disagree
22. I always doubt people's motives when they complement me.
- Strongly agree
  - Agree
  - Somewhat agree
  - Neither agree or disagree
  - Somewhat disagree
  - Disagree
  - Strongly disagree

23. I find it hard to trust people with whom I have little in common.

- Strongly agree
- Agree
- Somewhat agree
- Neither agree or disagree
- Somewhat disagree
- Disagree
- Strongly disagree

24. Most people are genuine.

- Strongly agree
- Agree
- Somewhat agree
- Neither agree or disagree
- Somewhat disagree
- Disagree
- Strongly disagree

## Appendix D

### Client Version of Social Network Questionnaire

Name: \_\_\_\_\_

Date Completed: \_\_\_\_\_

Instructions: For each item, provide a rating about your relationship with \_\_\_\_\_

1. How frequently do you have contact with this person?	Never	Rarely	Sometimes	Often	Always
2. How likely are you to go to this person when you have difficulties?	Never	Rarely	Sometimes	Often	Always
3. How well does this person understand you?	Not at all	Not much	Somewhat	Quite a lot	Very much
4. How much does this person offer you emotional support? E.g., trying to comfort you, listening to you or showing sympathy.	Not at all	Not much	Somewhat	Quite a lot	Very much
5. How much does this person offer you practical support? E.g., helping talk with school, social services, CAMHS, GP, parents/carers to resolve issues important to you.	Not at all	Not much	Somewhat	Quite a lot	Very much
6. How much does this person offer you useful information? E.g., giving you suggestions or sharing information that you can use to address problems.	Not at all	Not much	Somewhat	Quite a lot	Very much
7. How reliable is this person?	Not at all	Not much	Somewhat	Quite a lot	Very much
8. How often is your relationship with this person frustrating?	Never	Rarely	Sometimes	Often	Always
9. How much do you trust this person?	Not at all	Not much	Somewhat	Quite a lot	Very much

## Appendix E

### Clinician Version of Social Network Questionnaire

Name: \_\_\_\_\_

Date Completed: \_\_\_\_\_

Instructions: For each item, provide a rating about their relationship with  
\_\_\_\_\_

Do you know of this person?    Yes             No

1. How frequently do they have contact with this person?	Never	Rarely	Sometimes	Often	Always
2. How likely are they to go to this person when they have difficulties?	Never	Rarely	Sometimes	Often	Always
3. How well does this person understand them?	Not at all	Not much	Somewhat	Quite a lot	Very much
4. How much does this person offer them emotional support? E.g., trying to comfort you, listening to you or showing sympathy.	Not at all	Not much	Somewhat	Quite a lot	Very much
5. How much does this person offer them practical support? E.g., helping talk with school, social services, CAMHS, GP, parents/carers to resolve issues important to you.	Not at all	Not much	Somewhat	Quite a lot	Very much
6. How much does this person offer them useful information? E.g., giving you suggestions or sharing information that you can use to address problems.	Not at all	Not much	Somewhat	Quite a lot	Very much
7. How reliable is this person?	Not at all	Not much	Somewhat	Quite a lot	Very much
8. How often is their relationship with this person frustrating?	Never	Rarely	Sometimes	Often	Always
9. How much do they seem to trust this person?	Not at all	Not much	Somewhat	Quite a lot	Very much

## Appendix F

REC Favourable Opinion Letter



### London - Bloomsbury Research Ethics Committee

HRA RES Centre Manchester  
Barlow House 3rd Floor  
4 Minshull Street  
Manchester  
M1 3DZ  
Tel: 02071048127

**Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until**

25 June 2019

Miss Elise Draper

Department of Psychology & Language Science, Gower Street London, WC1E 6BT

Dear Miss Draper

**Study title:** Exploring how trauma, symptomatology and expectations of helping relationships are related to epistemic trust in adolescents.  
**REC reference:** 16/LO/2108  
**Amendment number:** Substantial Amendment 1  
**Amendment date:** 10 April 2019  
**IRAS project ID:** 217408

The above amendment was reviewed by the Sub-Committee in correspondence.

#### **Ethical opinion**

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

## Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering letter on headed paper [to be sent with PIS]	3	22 March 2019
Covering letter on headed paper [16LO2108 Substantial amendment cover letter]		25 April 2019
Notice of Substantial Amendment (non-CTIMP)	Substantial Amendment 1	10 April 2019
Participant consent form [Assent Form for YP 12-15]	4	22 March 2019
Participant consent form [YP 16 - 18]	3	22 March 2019
Participant consent form [Parent-Carer Consent Form]	4	22 March 2019
Participant information sheet (PIS) [PIS 16-18]	5	11 April 2019
Participant information sheet (PIS) [PIS Parent-Carer]	5	11 April 2019
Participant information sheet (PIS) [PIS 12-15]	6	11 April 2019
Research protocol or project proposal [JRO Protocol]	2	22 March 2019

## Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

## Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

## Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

## HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at:

<https://www.hra.nhs.uk/planning-and-improving-research/learning/>

<b>16/LO/2108: Please quote this number on all correspondence</b>
-------------------------------------------------------------------

Yours sincerely

**Reverend Jim Linthicum**  
**Chair**

E-mail: nrescommittee.london-bloomsbury@nhs.net

*Enclosures: List of names and professions of members who took part in the review*

*Copy to: Miss Elise Draper*

## London - Bloomsbury Research Ethics Committee

### Attendance at Sub-Committee of the REC meeting on 14 May 2019

#### Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Reverend Jim Linthicum	Hospital Chaplain	Yes	
Ms Pippa Sipanoun	Research Associate, Great Ormond Street Hospital	Yes	

#### Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Nina Bakhshayesh	Approvals Administrator