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Mentalizing, Epistemic Trust and the Phenomenology of Psychotherapy

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Abstract
This paper seeks to elucidate the phenomenological experience of psychotherapy in the context of the theory of mentalizing and epistemic trust. We describe two related phenomenological experiences that are the domain of psychotherapeutic work. The first is the patient's direct experience of their own personal narrative being recognized, marked and reflected back to them by the therapist. Secondly, this intersubjective recognition makes possible the regulation and alignment of the patient's imaginative capacity in relation to phenomenological experiences. In describing three aspects of the communication process that unfold in effective psychotherapeutic interventions – (1) the epistemic match, (2) improving mentalizing and (3) the re-emergence of social learning – the way in which any effective treatment is embedded in metacognitive processes about the self in relation to perceptual social reality is explained. In particular, attention is drawn to wider social determinants of psychopathology. We discuss the possible mechanism for the relationship between the socioeconomic environment and psychopathology, and the implications of this for psychotherapeutic treatment.
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Introduction

Historically, although there were moments of exchange between phenomenological approaches and psychoanalysis, there has also been something of a divide, with the two approaches developing in relative isolation [1]. This mainly has to do with the traditional emphasis in psychoanalysis on the role and nature of unconscious processes, whereas the phenomenological tradition typically focusses on the here and now of conscious, subjective experience. We believe that this has been unfortunate because any effective approach in psychotherapy should not only focus on the underlying psychological processes involved in the human mind, but also the more experience-near subjective functioning of individuals. This will be the central focus of this paper.

In psychoanalytic thinking, consciousness has been regarded as the less significant hand tool of the real work of mental activity, which takes place unconsciously. In this respect, psychoanalytic thinking – never normally chary of broaching the big questions of human experience – has not directly engaged with the "hard problem of consciousness" [2]. In this paper we argue that contemporary psychoanalytic thinking about mentalizing and epistemic trust provides us with a way into thinking about human consciousness and the phenomenological experience of psychotherapeutic intervention from which its effectiveness derives.

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Mentalizing is the term used to describe a particular facet of the human imagination: an awareness of mental states in oneself and in other people, particularly in explaining their actions. Epistemic trust is defined as openness to the reception of social knowledge that is regarded as personally relevant and of generalizable significance [3]. We will thus try to demonstrate that the process of *jointly* undertaking the metacognitive work of considering the subjective experience of being in possession of a mind is at the heart of the psychotherapeutic project [4].

Psychotherapy is centrally concerned with the problem of subjectivity, a shadowy artefact of human consciousness that is nevertheless a necessary construct for psychological health. Recent developments in thinking about the intrinsically social nature of higher-order cognitive function would lead us to add another critical adaptive purpose to the evolution of subjectivity: helping us to manage complex social relationships. This suggestion might be understood as part of a broader shift in thinking about the origins and functions of some of the characteristics that we identify as central to our identity as a species as serving the transmission of culture and social capabilities. A major expression of this is found in Mercier and Sperber's book *The Enigma of Reason*, in which they examine the question of the human capacity for reason, alongside an equally pronounced capacity for irrationality [5]. They argue that reason is primarily social, that the function of logic and reason is to enable us to cooperate as well as to negotiate and agree on social terms with others. A recent hypothesis presented by Mahr and Csibra [6] proposed, similarly, that one of the functions of episodic memory is to enable social communication.

Thus, memory of personal experience ensures that we have justifications for why we believe what we do, for keeping track of where we are placed in terms of obligations and commitments with others, whom we can rely on and whom we should regard with caution. These are key elements that enable social cooperation, social learning and the construction of a network of relationships that make culture and its transmission possible [6]. We have argued, in a similar vein, that human consciousness evolved to allow us to share our experiences, to communicate a "shared narrative" on which relationships, social ties and group cohesion can all be built [7]. We become conscious of those aspects of the world that others reflect on as well, and this applies equally to our internal subjective world [7].

Mentalizing, Metacognition and Social Communication

This paper will discuss the phenomenology of psychotherapy in the light of this thinking about the inter-relational drivers of the human experience of subjectivity, and we will suggest that the effectiveness of treatment derives from the experience of social metacognition, which triggers a capacity for social learning. Mentalizing theory, to put it in phenomenological terms, is explicitly based around the human experience of qualia (mainly but not exclusively social qualia) and, in particular, metacognition in relation to qualia. Qualia refers to the perception of the quality of an experience – mentalizing is about the perception and interpretation of behaviour, and thus from a phenomenological perspective it concerns the process of reflection in relation to qualia.

As with subjectivity, the existence of qualia has been disputed by philosophers of the mind, but whether or not qualia exist [8], there can be no debate about the fact that our *perception* of qualia exists, and that the loss or distortion of that experience is psychically highly disruptive and potentially terrifying. There is consistent evidence that any form of mental disorder is associated with a temporary or chronic distortion of internal and/or external reality [9]. Awareness in relation to mental states is perforce bound up with the emergence of imagination. Beyond a biological resonance to others' emotional states, we have to *imagine* their phenomenological experience, their thoughts and feelings. Indeed, the leap forward in the development of the complexity of human tools requiring collaboration in construction coincides with the emergence of human objects that are the products of imagination, e.g., the torso of a lion with the head of a human, and complex representations (such as cave drawings) [10, 11]. With imagination, of course comes the potential for unhelpful – indeed, frightening – possibilities.

In individuals who are seriously disrupted in their capacity to mentalize, qualia become disrupted – in the first instance, this is most conspicuous in relation to social and emotional experiences, but it is not limited to such. Commonly cited examples of qualia are subjective experiences of colour or the smells of food; distress or distortions in thinking are all capable of disrupting the ways in which we might enjoy, interpret or react to such perceptual experiences. Martin Debbané's work on the psychosis continuum and the role of early, subtle mentalizing disruptions that may precede more conspicuously aberrant mentalizing difficulties is relevant here [12]. Descriptions of the non-mentalizing modes of psychic equivalence, the

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pretend mode and the teleological mode all involve, according to the individual, distortions in the way in which he or she responds to perceptual experiences of the real world. In the psychic equivalence mode, thoughts and feelings become "too real" to a point where it is extremely difficult for the individual to entertain possible alternative perspectives. When mentalizing gives way to psychic equivalence, what is thought is experienced as being real and true, leading to what clinicians describe as "concreteness of thought" in their patients. In the teleological mode, states of mind are recognized and believed only if their outcomes are physically observable. Hence, the individual can recognize the existence and potential importance of states of mind, but this recognition is limited to very concrete situations. For example, affection is perceived to be true only if it is accompanied by physical contact such as a touch or caress. In the pretend mode, thoughts and feelings become disconnected from reality. In more extreme cases, this may lead to feelings of derealization and dissociation.

We have previously suggested – for example, in working with an adolescent with emerging borderline traits – that there might be value in an initial approach being a physical one, such as running with them, and discussing with them what the experience of running was like. This thinking is based on the idea that individuals who are really poor at mentalizing require not just cognitive interventions, but ones that relate to the body more directly; it is not possible to access mentalizing if the self is overwhelmed by negative interference, which impairs normal cognitive function. As mentioned, Debbané's research on mentalizing and psychosis has extended this line of thinking [12, 13], as well as Fotopoulou and Tsakiris's work on embodied mentalizing [14].

Developing this thinking, we would like to describe here two related phenomenological experiences that occur in psychotherapeutic work. The first is the patient's direct experience of their own personal narrative being recognized, marked and reflected back to them by the therapist. Secondly, this intersubjective recognition makes possible the regulation and alignment of our imaginative capacity in relation to our phenomenological experiences. The harnessing of these two metacognitive activities – (a) the conscious recognition of one's personal narrative by another (with the intersubjective acknowledgement of subjectivity that this entails) and (b) assistance in regulating the social imagination – generates the possibility of "therapeutic help" through the adaptive social communication that is made possible by this process.

We will begin with the idea of personal narratives. By this we mean the ways in which we understand ourselves in relation to the world, our history and our relationships. Each of us will have different and possibly competing narratives by which we understand who we are and what is going on for us at any particular time. From a phenomenological perspective, these represent various ways of *Dasein* ("being in the world") [15, 16]. We might be more immediately aware of and preoccupied with some of these narratives than others, but they are all experientially accessible characterizations of one's self, and together they constitute one's "sense of self." That all individuals have a personal narrative, an imagined sense of self evidenced by our experiences, has long been recognized by phenomenologists [17], and the biological reality of this has been impressively demonstrated by the research summarized by Northoff and Huang [18].

We suggest that one of the key experiences that makes therapeutic change possible is the recognition of these personal narratives – notably, the minor, more complex narratives as well as the predominant story of one's self that may be present. The therapist's recognition and articulation of these narrative threads is a significant part of the therapeutic process because, we have argued, this experience is a potent ostensive cue for the stimulation of epistemic trust (defined as openness to the reception of social knowledge that is regarded as personally relevant and of generalizable significance) [3, 19]. The recognition of agency suggested by the explicit understanding and elucidation of another's personal narrative signals a shared intentionality. In brief, if individuals experience themselves as being understood, they will be inclined to learn from the person who has shown that he or she understands them. This will include learning about oneself, but also about others and about the environment in which one lives – most significantly, how to navigate the social and cultural environment with all its complexities and challenges.

In a frequently cited paper [20], James Strachey introduced the concept of "mutative interpretation" – the therapist acting as an auxiliary "superego" helping the patient to recognize impulses or elements in him- or herself in order to produce change in the patient's mental organization. We suggest that the conscious and explicit articulation of difficult, not consciously recognized narratives by the therapist acting as a superego is such a powerful tool – in terms of the evolutionary thinking we have described here – because it enables patients to develop their capacity for social learning. The concept of the auxiliary superego might be understood as holding an epistemic authority to which we are highly primed, in evolutionary terms, to respond.

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In order to safely depend on others to learn about reality, we need to be able to identify those who are reliable sources of information. The young human needs to be able to distinguish trustworthy, benevolent and reliable sources of knowledge from those communicators who are either poorly informed or badly intentioned. In either case, the latter are the purveyors of useless or deceptive information. Thus, in order to ensure effective cultural knowledge transfer via teaching, humans needed to evolve a reliable way of distinguishing trustworthy sources of knowledge. Trust in knowledge (which we call epistemic trust, following Sperber et al. [21] and Wilson and Sperber [22]) is at the heart of what it means to be a human. All young humans are at the mercy of a knowledge differential, uncertain about the trustworthiness of the information they are about to receive, but they are able to rapidly establish epistemic trust in order to benefit from a rapid and efficient system of knowledge transfer. Epistemic vigilance is the self-protective suspicion against potentially damaging, deceptive or inaccurate information [21]. The capability of vigilance, as well as a mechanism for selectively circumventing it, must be profound and deeply etched into our human origins.

It is clear that the absence of epistemic trust would deeply disadvantage an individual in most social contexts. The loss of this key process for the efficient acquisition of cultural knowledge has significant implications for social functioning. Individuals may become limited in their ability to update their understanding of potentially rapidly changing social situations and appear inflexible or even rigid in the face of social change.

Why would an individual fail to experience epistemic trust even in situations where trust was warranted – that is, where their personal narrative was appreciated? There are two obvious reasons. First, adversity and deprivation, when tantamount to trauma, can generate chronic mistrust by inhibiting imagination, creating an overarching avoidance of mentalizing and an almost phobic avoidance of mental states, leaving the individual deeply vulnerable in most social situations. We use "imagination" here to refer to the capacity to form a second order of representation, harking back to the original Latin definition of "imagine" ("to form an image, represent"). Even in the absence of such a pervasive failure of imagination, inadequate mentalizing may lead traumatized individuals to be biased in their perception of social reality [23–26] and misrepresent how others represent them, leading them to feel persistently misunderstood.

Secondly, the long-term outcome of epistemic mistrust secondary to the failure of imagination we describe here may create problems for individuals who have distorted personal narratives that generate inaccurate views of the self, so that even an accurate perception of one's personal narrative by others is not experienced as a match, and a painful experience of interpersonal alienation persists. Conversely, in yet other instances, deprivation and trauma may generate inappropriate trust. We understand such excessive epistemic credulity as triggered by a hyperactive or unmoored social imagination generating a personal narrative that is so diffuse that the individual concerned is unable to judge whether another person's perception of them is accurate. Excessive credulity results as all personal narratives feel as if they "fit" sufficiently for trust to be generated, making the person vulnerable to exploitation. Of course, limited imagination may cause profound misperceptions of the other's representations of one's personal narrative, and an illusory fit is created where none exists in reality. There may be many other possibilities.

We suggest that in all these permutations, individuals' social experience leads them to encounter problems in learning from others, which in turn creates significant problems in adaptation when they attempt to adjust to a frequently challenging and changing social world. However, all these permutations possess a shared quality that derives from the individuals' difficulty in being able to work with other minds to rectify their perception of their own mind in relation to the social environment in a way that delivers affect regulation and helps to shore up executive function. Individuals in a state of heightened epistemic mistrust will not benefit from the access to other people's minds that could serve to regulate their own imaginative activity. Without the social metric that epistemic trust enables, the imagination may "run riot," and go substantially beyond the shared reality that people ultimately must agree on in order to collaborate.

Difficulties in reaching an agreement with other minds are characteristic of many forms of mental health disorder, and personality disorder perhaps most paradigmatically. The system of cultural transmission that humans have evolved requires imagination (of which mentalizing is one aspect) in order to establish trust; however, the ensuing transmission of knowledge places a constraint on the imagination to ensure that there is an agreed version of reality. Being able to mentalize one another makes it possible to have a collectively agreed imagination, which makes human cooperation possible [27]. The significance of epistemic trust in relation to our model of psychopathology is therefore that it enables individuals to align their social imagination with the prevailing social reality

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in an adaptive way, creating the foundation for the intergenerational transmission of ideas and the creation of social networks that in turn support culture.

We have recently suggested that effective psychotherapeutic practice taps into this human capacity for imagination, and that psychopathology and disruptions in mentalizing involve dysfunctional imaginative processes that obstruct the individual's "salutogenic" exposure to social communication [28, 29] (for a discussion of the idea of "salutogenesis" as an approach that considers the factors supporting health, see Antonovsky [30]). In particular, the interpersonal component of this process is essential. In recognizing and jointly considering the subjective experience of the individual, it becomes endowed with a conscious significance. This recognition by consciousness is valuable because it creates the conditions for epistemic trust and the possibility of adaptive social communication and learning with others.

The Three Aspects of the Communication Process within Psychotherapy

We have described the processes that underpin effective psychotherapy elsewhere (we have previously labelled these "the three communication systems") [29]. Here we would like to approach these processes in terms of phenomenological experience, i.e., in terms of the subjective experience underlying them. In phenomenological terms, it is an account of change in relation to experiences involving the *Eigenwelt* ("the own world"), the *Mitwelt* ("the with-world," involving interpersonal relatedness) and the broader *Umwelt* ("the around-world"), to use the terminology of the famous phenomenological psychiatrist Binswanger [15]. Through this account of the communicative unfolding of psychotherapy, we hope to elucidate how it is embedded in metacognitive processes regarding the self in relation to perceptual social reality. In addition to this, we would like to bring in social reality in a more immediate sense, in considering the impact of the phenomena of socioeconomic deprivation, inequality and social isolation on psychopathology.

(1) The Epistemic Match

All evidence-based psychotherapies provide a coherent framework that enables the patient to examine the issues that are deemed to be central to him or her, according to a particular theoretical approach, in a safe and low-arousal context. Psychotherapeutic models differ in detail, but they generally work – directly or indirectly – to develop strategies to handle how one thinks and feels with regard to oneself (the *Eigenwelt*) and restructure thinking about interpersonal relationships (the *Mitwelt*). Perhaps more importantly, however, all evidence-based psychotherapies provide the patient with a model of the mind and an understanding of their disorder, as well as a hypothetical appreciation of the process of change, that are accurate enough for the patient to feel recognized and understood as an agent. Any therapeutic model – i.e., understanding the causes of the problem and their possible resolution – can be effective only insofar as it results in the feeling of being mirrored in a marked way, which leads to the feeling of being understood. This, in our view, is one of the most powerful human experiences, leading to the restoration of feelings of agency and selfhood. These experiences in turn lead to recovery of mentalizing and epistemic trust.

In essence, we suggest that such explanations and suggestions may be seen as ostensive cues that signal to patients the relevance to them of the information that is being conveyed. Csibra and Gergely [31] take the concept of "ostensive cues" – discussed originally by Bertrand Russell [32], but extensively used by Sperber and Wilson [33] – to mean that certain signals are employed by an agent and prepare the addressee for the intent of the agent to communicate. They are signals designed to trigger epistemic trust. Examples of ostensive cues are eye contact, eyebrow raising, contingent reactivity and infant-directed speech ("motherese"). The particular process of ostensive cueing in psychotherapy – via the therapist's rich and careful mentalizing of the patient – is important because it allows patients to reduce their epistemic hypervigilance as they increasingly see the model's relevance to their own state of mind. Thus, acquiring new skills and learning new and useful information about oneself, as well as doubtlessly being useful in their own right, have the non-specific effect of creating epistemic openness. This openness makes it easier for the patient to learn the specific suggestions conveyed within the model. A virtuous cycle is created: the patient "feels" the personal truth of the content conveyed within the therapeutic model, which, because it is accurate and helpful, generates epistemic openness. The growth of epistemic trust allows the patient to take in further information that also serves to reassure and validate him or her.

As will be explained in more detail below, in our discussion of the third aspect of communication, we need to take into account the role of the wider social system (the *Umwelt*) in generating a feeling of subjective alienation and epistemic trust. The first therapeutic task at hand is

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therefore to recognize this experience, to restore a feeling of subjectivity and epistemic trust. Any theoretical model – no matter how robust or accurate it may be – will be completely powerless in patients with feelings of subjective alienation and epistemic mistrust unless this task is achieved. For the sake of narrative clarity, we are conveying this as a linear progression. The clinical reality is that it is a task that will in most cases need to be revisited and will overlap with the processes unfolding as part of communication aspects 2 and 3. As noted, this alienation might originate from particular psychological problems – for example, a severely depressed patient feeling completely hopeless and beyond help – but an individual's social circumstances might indeed be highly alienating (acute social deprivation is a case in point); for such individuals, it might be adaptive to distrust those who claim to offer help.

The approach to psychopathology that we have described here is an evolutionary one that regards many forms of disorder as originating as a form of adaptation to social circumstances [28, 29]. The "social alienation" associated with inhabiting a more broadly non-mentalizing social system might be understood as a generalized breakdown in epistemic trust. A recognition of the presence of these wider processes may be a necessary extension to the dyadic emphasis of the therapeutic approach in order to give what the therapist is communicating a sense of phenomenological reality. It is through the therapist's understanding of, adaptation to and effective marked mirroring of the patient's vigilant stance and its origins that the work of the first aspect of communication is achieved.

(2) Improving Mentalizing

As noted above, through passing on knowledge and skills that feel appropriate and helpful to the patient, the clinician is actively recognizing the patient's agency. The clinician's presentation of information that is personally relevant to the patient serves as a form of ostensive cueing that conveys the impression that the clinician seeks to understand the patient's perspective; this in turn enables the patient to listen to and hear the clinician's intended meaning. In effect, the clinician is demonstrating how he or she engages in mentalizing in relation to the patient.

It is important that in this process both patient and clinician come to see each other more clearly as intentional agents. For example, when clinicians show that their mind has been changed by the patient, they give agency to the patient and increase his or her faith in the value of social understanding. The context of an open and trustworthy social situation facilitates the achievement of a better understanding of the beliefs, wishes and desires underpinning the actions of others and of the self. This allows a more trusting relationship to develop between clinician and patient. Ideally, the patient's feeling of having been sensitively responded to by the clinician opens a second virtuous cycle in interpersonal communication in which *the patient's own capacity to mentalize is regenerated*. This, we believe, constitutes an important turning point in all types of psychotherapy: when patients begin to develop genuine curiosity and interest in their own mind as well as the minds of others around them, including the therapist.

Understanding the patients' subjectivity is vital to this process, as the patients' self-discovery as an active agent occurs through social interchange, where they experience themselves as an agent in the way their clinician thinks of them – it could be said that they "find themselves in the mind of the clinician." It is also vital to a further function of therapy: the rekindling of the patients' wish to learn about the world, including the social world. We believe that this is a complex and non-linear process, but it can be summarized briefly as follows: the insight obtained in therapy, whatever its content, creates or recreates the potential for the patient to have a learning experience, which in turn makes other similar learning experiences more productive because it *enables the patient to adopt a stance of learning from experience by increasing their capacity to mentalize*.

The benefit of improved mentalizing as part of the social process of psychological therapy feeds back to increasing epistemic openness in two ways. Firstly, with improved mentalizing, individuals become more sensitive and accurate in identifying their personal narrative (their phenomenological experience) in the implicit presentation of them by the therapist. Secondly, improved mentalizing also generates an enhanced and more nuanced self-experience that in turn facilitates the process of self-recognition in the social context of therapy. In both ways, increasingly robust mentalizing will serve to gradually improve communication between therapist and patient and enable the patient to benefit from the new knowledge that the therapeutic process brings with it.

As an example, phenomenological psychiatry has linked depression to a disturbance in the experience of time [34]: past, present and future do not have the same differentiated meaning for depressed patients as they have for individuals without disturbed mood, since they all feel equally painful and immovable [see also 35]. This experience of being locked in the "specious present" [36]

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leads to feelings of helplessness and hopelessness, and disturbances in the experience of time. Yet, what we typically observe in this phase of treatment is that when the depressed individual recognizes, in dialogue with a reflective therapist, that this feeling is borne out of psychic equivalence (i.e., the conviction that what one thinks or feels is true), rather than being a true reflection of reality, it opens up the possibility of recognizing other ways of seeing the self in time. This experience helps to open up the mind of the patient more generally to other, alternative ways of thinking and feeling about the self, other ways of *Dasein*.

(3) The Re-Emergence of Social Learning outside Therapy

The improved mentalizing that results from effective treatment brings about improved social relations and experiences outside the consulting room. Improved levels of trust and the breaking down of rigid ways of interpreting and responding to social experiences pave the way for the patient to accumulate experiences of social interaction that are benign, or that are at least manageable in terms of maintaining resilient mentalizing. This creates another virtuous circle in which more balanced and robust mentalizing generates and supports deeper, wider and increasingly meaningful access to social information and social networks.

This final, critical stage of social learning beyond therapy is of course contingent on the individual's social environment being benign, or at least "benign enough." Therapeutic change can be sustained, according to this thinking, only if patients are able to use, and even to change (through the seeking out of more mentalizing relationships), their social environment in a way that allows them to continue to relax their epistemic hypervigilance and foster their mentalizing strengths.

We suggest that for individuals who are enduring mental health difficulties in the context of greater socioeconomic inequality and deprivation, aspect 3 of the communication process may be of heightened significance. We would like to explain the relevance and significance of this process here, as it speaks to the phenomenological experience of therapeutic change, and the importance of considering the *Umwelt*, the broader sociocultural context, in conceptualizing therapeutic change.

We know that at least some risk factors cut a swathe through the complexity of individual diagnoses, and perhaps the most powerful of these is that of socioeconomic status [37, 38]. There is unequivocal evidence that social and economic inequality is strongly connected with mental ill health [39–41], and poverty is one of the best-documented risk factors for both internalizing and externalizing problems [42]. It has been argued that the dominance of biological and individual psychological perspectives may have distracted clinicians from considering broader social perspectives [43, 44]. Indeed, we are increasingly of the view that the role of these wider systemic social experiences – while abundantly clear to many clinicians working on the front line of mental health care – is theoretically underaccounted for in existing conceptualizations of psychopathology. In our description of the aspects of communication in effective psychotherapy, we would like to propose a model that takes into account these wider social phenomena and their relationship to individual psychic distress.

We have evidence that individuals who are socioeconomically less privileged tend to behave in more community-oriented and socially oriented ways in interpersonal trust experiments than do more affluent individuals [45]. Less affluent individuals are more engaged with and dependent on their community; wealthier and more socially protected individuals have a stronger perception of their self-agency and thus tend to be less community focused [46–48]. As a result, individuals functioning in a lower-socioeconomic-status environment are also more sensitive to their social environment, its reliability and how benign or supportive it may be [49, 50]. The flipside of this is that when the social environment is hostile or unsupportive, the individual may be more responsive to the meaning and significance of that, increasing the breakdown in social learning, and resulting in what is recognized in sociological terms as "social alienation." It is this effect, we posit, that contributes to the relationship between socioeconomic factors and poor mental health outcomes. According to this thinking, the reason why inequality rather than the absolute income level is so pernicious to mental health can be explained in terms of the sense of social vulnerability and breakdown associated with it [51, 52]. In summary, socioeconomic disadvantage is likely to be a powerful cause of mental disorder across diagnostic categories, but its impact is moderated by interpretation of the meaning of disadvantage.

A similar complex pattern of how overarching social factors have an impact on individual risk emerges from studies of the association of ethnicity with mental disorder. Among children, subjective well-being is either unrelated to [e.g., 53] or modestly associated with [e.g., 54] ethnicity. Racial discrimination, however, is a powerful predictor of general psychopathology [55], with the most

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powerful associations observed for depression and anxiety [56, 57] and conduct problems [58, 59]. As one might expect from the broad range of mental disorders found at greater prevalence with groups subject to racial prejudice, it is once again the shared transdiagnostic component of psychopathology that correlates with the experience of racial discrimination [60].

The implication of this thinking is that this third aspect of communication is of particular significance to patients who are relatively socially powerless or deprived. The challenge for the therapist is to support the patient in building or sustaining mentalizing social relationships in what might be more challenging environments. Nevertheless, it is only if such conditions can be created that the hope of effective therapeutic change can be realistically entertained. This is because it is only once patients encounter the phenomenological reality of such an environment that – for entirely adaptive reasons – we can reasonably expect them to become open to the social learning and sustenance made possible by their increased mentalizing capacity.

Conclusions

We believe that the recovery of the capacity for social information exchange may be at the heart of effective psychotherapies. As clinicians, we often assume that what happens in the consulting room is the primary driver of change, but experience shows us that change is also brought about by what happens beyond therapy, in the patient's social environment. Studies in which change was monitored session by session have suggested that the patient-clinician alliance in a given session predicts change in the next session [61]. This indicates that the change that occurs between sessions is a consequence of changed attitudes to learning engendered by therapy, influencing the patient's behaviour between sessions.

The factors associated with "therapies that work" create experiences of truth – subjectively felt truth – which in turn encourage the patient to learn more. In this process, via a non-specific pathway, the patient's capacity to mentalize is fostered. Both of these systems would be expected to lead to symptomatic improvement. Improved mentalizing and reduced symptomatology both improve the patient's experiences of social relationships. However, it is likely that these new and improved social experiences, rather than just what happens within therapy, serve to erode the epistemic hypervigilance that has previously prevented benign social interactions from changing the patient's experience of themselves and of the social world. *Meaningful change is thus possible only if the person can use their social environment in a positive way (and if the social environment is sufficiently supportive to allow this to happen).* For this to happen, recognition of self-agency is key, and this recognition is best achieved through the ostensive cues that are provided by feeling appropriately mentalized by another person. For the social environment to be accurately interpreted so that it can provide opportunities for new learning, mental state understanding of others' actions and reactions is critical – and only improved mentalizing will achieve this. Hence, as in the phenomenological tradition, we believe that changes in the subjective experience of the self, particularly those that take place in relation to others that we imbue with epistemic trust, are at the heart of therapeutic change.

Disclosure Statement

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Author Contributions

All authors contributed equally to the writing of this paper.

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