Why is it so hard to learn to do things differently? On not being able to learn from experience

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Chief Executive, Anna Freud Centre
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Progress in the treatment of physical and mental illness

- The **overall prevalence** of mental illness has **not changed** in 30-40 yrs
Progress in the treatment of physical and mental illness

- The **overall prevalence** of mental illness has **not changed** in 30-40 yrs

**Why?**

- We can alleviate the suffering from mental disorder but we cannot cure it
- There are no effective preventive interventions
Why have we failed to bend the curve?

■ Diagnosis

➢ Imprecise Dx ← Co-occurrence and no biological validity ← General psychopathology (p factor)

■ Treatment

➢ Lack of discrimination ← What treatment works ..........(forget the Whom)

➢ Lack of availability and delay in treatment ← 65% not receiving care ← DUP 74 weeks

■ The context of treatment

➢ Lack of measurement – We can’t manage what we can’t measure. (Peter Drucker)

➢ Social contextual moderation of mental disorder ← low SES, white British, SEN, from disrupted homes (4x)
1. The Diagnosis:

A general psychopathology factor
Models of covariation of symptoms/diagnoses

A. Correlated-Factors Model

Internalizing

Externalizing

Psychotic Experiences

MDD  GAD  Fears  CD  SUD  ADHD  Schz  BPD  OCD

From Caspi & Moffitt (2018)
Models of covariation of symptoms/diagnoses

C. Bifactor Model

- General Pathology
  - Factor p
  - MDD
  - GAD
  - Fears
  - CD
  - SUD
  - ADHD
  - Schz
  - BPD
  - OCD

- Internalizing
- Externalizing
- Psychotic Experiences

From Caspi & Moffitt (2018)
A general psychopathology factor in early adolescence

Praveetha Patalay, Peter Fonagy, Jessica Deighton, Jay Belsky, Panos Vostanis and Miranda Wolpert

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

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

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

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

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

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

community-based sample aged 11-14 years (N= 23, 477)

## Logistic regression predicting future caseness

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>Wald Chi-square</th>
<th>Odds-ratio</th>
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<tbody>
<tr>
<td><strong>N=10,270</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>2-factor model</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internalising</td>
<td>.49***</td>
<td>76.4</td>
<td>1.80</td>
</tr>
<tr>
<td>Externalising</td>
<td>1.41***</td>
<td>689.64</td>
<td>4.11</td>
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<tr>
<td><strong>Bi-factor model</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internalising</td>
<td>.22</td>
<td>4.43</td>
<td>1.25</td>
</tr>
<tr>
<td>Externalising</td>
<td>1.43***</td>
<td>413.74</td>
<td>4.16</td>
</tr>
<tr>
<td>P-Factor</td>
<td>2.33***</td>
<td>479.01</td>
<td>10.30</td>
</tr>
</tbody>
</table>
Shared and specific effects of mental disorders and risk of suicide attempt during a 3-year follow-up period

Men (n=14,564)

There is no specific dimension of psychopathology or disorder with modification index greater or equal to 10 to predict suicide attempt in men.
P factor in PDs: the DSM factor structure

Sharp et al., 2015 *Journal of abnormal psychology*

N=966 inpatients

**BPD**
- .78
- Avoids abandonment
- Interpersonal Instability
- Identity disturbance
- Self-harming impulsivity
- Suicidality
- Affective instability
- Emptiness
- Intense anger
- Transient dissociation

**AVPD**
- .76
- Avoids social work
- Must be liked
- Restraint in intimacy
- Preoccupied with rejection
- socially inhibited
- Views of self as inept
- No risks or new activities

**OCPD**
- .41
- Orderly
- Perfectionistic
- Workaholic
- Moral inflexibility
- Hoarding
- Reluctance to delegate
- Miserly
- Rigidity

**SZTPD**
- .60
- Ideas of reference
- odd beliefs
- Odd perceptions
- Odd thinking/speech
- Suspicious
- Constricted affect
- Odd behaviour/appearance
- Lacks close friends
- Social anxiety

**NPD**
- .72
- Grandiose
- Preoccupied with fantasies
- Believes s/he is special
- Needs admiration
- Entitlement
- Exploitative
- Lacks empathy
- Envious
- Arrogant

**ASPD**
- .92
- Failure to conform
- Deceitfulness
- Impulsivity
- Irritable, aggressive
- Disregard for safety
- Irresponsible
- Lacks remorse

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

Sharp et al., 2015 *Journal of abnormal psychology*

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**UNACCEPTABLE MODEL FIT**

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

Sharp et al., 2015 *Journal of abnormal psychology*
P factor in PDs: does EFA replicate the DSM factor structure?

Excellent model fit:
\[ \chi^2(897) = 1110.58, p < .001 \]
RMSEA = 0.02 [0.01, 0.02], \( p = 1 \)
CFI = 0.97
TLI = 0.97

N=966 inpatients

Sharp et al., 2015 Journal of abnormal psychology
P factor in PDs: Exploratory bifactor model

Excellent model fit:
$X^2_{(897)} = 1030.09, p < .001$
RMSEA = .02 [.01, .02], $p = 1$
CFI = .98
TLI = .97

Only factor loadings $|\geq 30|$ are shown

Average load = .81
100% of criteria marking the *specific* factor

Average load = .73
78% of criteria

Average load = .65
100% of criteria

Sharp et al., 2015 *Journal of abnormal psychology*
General and specific factors for personality disorders

Longitudinal relationships

- 4 measure waves: baseline, 2, 4, 6 and 10 years
- N = 733

Wright et al. (2016) JAP

Detachment
- .62
- .49

Dependency
- .28
- .52
- .38

Compulsivity
- .68
- .91

Dominance
- .45
- .48

Disinhibition
- .88

Paranoid
- Schizotypal
- Schizoid
- Avoidant
- Dependent
- Obsessive
- Borderline
- Histrionic
- Narcissistic
- Antisocial

Good fit ($\chi^2_{26} = 196.28, p < .001; \text{RMSEA} = .048; \text{CFI} = .96; \text{TLI} = .92; \text{SRMR} = .036$)

Wright et al. (2016) JAP
Child Maltreatment and psychopathology: Comparing structural models

1. Classical Model: Three correlated factors (*p<0.01)

   - History of Child Maltreatment
     - Internalising
     - Externalising
     - Thought Disorder

   
   - .183*
   - .193*
   - .203*

2. Bifactor Model: P Factor (*p<0.01)

   - Factors (*p<0.01)

Caspi, A., et al. (2013)
**Child Maltreatment and psychopathology: Comparing structural models**

1. **Classical Model:** Three correlated factors (*p<0.01)

   - History of Child Maltreatment
   - Internalising
   - Externalising
   - Thought Disorder

   - .098
   - .023

2. **Bifactor Model:** P Factor (*p<0.01)

   - History of Child Maltreatment
   - Internalising
   - Externalising
   - Thought Disorder

   - .210*

*Caspi, A., et al. (2013)*
The observed diagnostic instability and declines in symptoms of PDs are largely driven by changes in general PD rather than stylistic factors.

Wright et al. (2016) JAP
2. The treatments: A story of decline and generalisation
The effect CBT for depression across time 1977-2014
A meta-analysis by Johnsen & Friborg, 2015

K= 70 published studies
Within-group (pre-post) k=53
Between-groups with waiting list, k= 17
Average quality of studies (RCT-PQRS)= 28.4 (7.5)

N= 2,426
Average n(sd)= 34.6 (34.1)
Males= 30.9%
Patients with comorbidity= 43%

Average CBT sessions= 14.6 (5.12)
Mean baseline BDI= 26.1 (4.1)
Males= 30.9%
Patients with comorbidity= 43%

Patients in remission at post-treatment
57% of patients had remissions

Change in BDI scores at post-treatment
Average weighted effect size for BDI
$g = 1.58 \ (1.43 – 1.74)$

Change in HDRS scores at post-treatment
Average weighted effect size for HDRS
$g = 1.69 \ (1.48 – 1.89)$
The effect CBT for depression across time 1977-2014
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Patients in remission at post-treatment
Change in BDI scores at post-treatment

Change in HDRS scores at post-treatment

Client related:
- Age
- Gender
- Comorbidity
- Medication
- Severity
- Associated problems

Therapist related:
- Competency

Treatment related:
- Number of sessions
- Beck’s manual
- Adherence check
- Analysis method
- Study quality

57% of patients had remissions
Average weighted effect size for BDI
$g = 1.58$ (1.43 – 1.74)
Average weighted effect size for HDRS
$g = 1.69$ (1.48 – 1.89)
Effect sizes on comparative studies of psychotherapy for BPD decrease by year of publication

Fonagy, Luyten & Bateman, 2017 JAMA Psychiatry

Weisz et al. (2018) Perspectives on Psychological Science

Weisz et al. (2018) Perspectives on Psychological Science

Weisz et al. (2018) Perspectives on Psychological Science
NEWS FLASH

CBT equivalent to Psychodynamic Psychotherapy for MDD
(N = 341)

Dreissen et al. (2013)
Enhanced CBT equivalent to Focal Psychodynamic Therapy and Optimised TAU for Anorexia Nervosa (N = 341)

Dialectical Behaviour Therapy is equivalent to General Psychiatric Management for BPD (N = 180)

McMain, et al., (2009)
Group MEmory specificity training (MEST) and group psychoeducation and supportive counselling (PSC) are equivalent for adolescent in the treatment of recurrent depression (N = 67)

Werner-Seidler et al., (2018)
CBT, Short-term Psychodynamic Psychotherapy (STPP), and Brief Psychological Intervention are equivalent for adolescent depression (N = 497)
Effect of Prolonged Exposure Therapy Delivered Over 8 Weeks vs Present-Centered Therapy on PTSD Symptom Severity in Military Personnel (N = 307)

Prolonged Exposure Therapy vs Present-Centered Therapy

<table>
<thead>
<tr>
<th>Time Relative to End of Treatment</th>
<th>Spaced therapy (n=109)</th>
<th>PCT (n=107)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>26.4 ± 3.2</td>
<td>26.5 ± 3.1</td>
</tr>
<tr>
<td>End of Treatment</td>
<td>26.1 ± 3.4</td>
<td>27.0 ± 3.5</td>
</tr>
<tr>
<td>2 wk</td>
<td>26.0 ± 3.3</td>
<td>27.0 ± 3.6</td>
</tr>
<tr>
<td>12 wk</td>
<td>25.9 ± 3.2</td>
<td>27.0 ± 3.4</td>
</tr>
<tr>
<td>6 mo</td>
<td>25.8 ± 3.1</td>
<td>26.9 ± 3.3</td>
</tr>
</tbody>
</table>

No. of participants

Spaced therapy: 109, 79, 76, 63, 49
PCT: 107, 86, 77, 69, 53

Foa et al., (2018)
CBT, Person-Centred Psychotherapy (PCT), and Psychodynamic therapies are equivalent in UK primary practice (N = 3,015)
What happens when you ask a room of psychotherapists whose approach is the most effective?

What can be done to end this unseemly behaviour?
What happens when you ask a room of psychotherapists whose approach is the most effective?

What can be done to end this unseemly behaviour?
Why are therapies equal and becoming apparently less effective?

- **Paradigm** has been shifting more and more towards addressing specific dysfunctions – therapies more and more specialized
  - Treatments addressing specific underlying pathologies while change process is likely to be transdiagnostic
- **Same protocol** for a range of disorders (e.g. Acceptance and Commitment Therapy or ACT: Hayes, 2015; MBT Bateman, 2016)
- **Individually** structured protocols for the same diagnoses (Chorpita & Daleiden, 2014).
3. The context:
A cultural re-education:
(Very) Old dogs......
You will never amount to anything if you hold a ball like that!

Let the boy dream Ivan, He is a born dilettante!

I want to write my PhD on the “Use of low signal-to-noise ratio stimuli for highlighting the functional differences between the two cerebral hemispheres”.

You look smug now but you will lose your hair just like Dad.
Criticisms of attachment theory

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

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

**WEIRD: Western, Educated, Industrialised, Rich & Democratic**

Fonagy & Target, 2007; Röttger-Rössler, 2014; Otto, 2011)
WEIRD data

Who is our knowledge based on?
The WEIRD world: 12% of global population
The rest of the world: 88% of global population
96% of the subjects in psychological samples come from WEIRD countries with only 12% of the world’s population.

*Henrich et al 2010, BBS
WEIRD data

A randomly selected American undergraduate is \textbf{more than 4,000 times more likely} to be a research participant than is a randomly selected person from outside of the West.

*Henrich et al 2010, BBS*
The cultural specificity of sensitive responsiveness

- **Face-to-face** interaction
- **Infant’s** point of **view** is paramount
- **Verbal** and vocal exchange (‘Serve & Return’)
- Learns primarily **about self as** an independent **agent**
- Only learns **secondarily** about **others**
Caregiving **beyond** the WEIRD world

- **Proximal** caregiving
- Infant **facing outward**, seeing the world as others see it
- Supported to take the **perspective of others**
- Caregiver **instructs**, guides and directs the infant ‘**apprentice**’
- Only learns **secondarily about self**
Secure attachment to an individual parent makes limited sense in certain evolutionary contexts...
Alertness and suspicion is more likely to ensure survival
• **Dyadic**, turn-taking, ‘smoothly completed’ interactions
• Supports the **cultural ideal** of the **infant** as an **agent sensitized to use personal qualities and attributes as the primary referent of actions**
• When infant **recognises** the **mother’s representation** of him as the ‘**central agent**’
• This creates the ‘**click**: epistemic match
• **But** perhaps this experience is e.g. of broader category
Sensitivity is biologically a group phenomenon

- Use of the sensitivity **construct restricted to single-caregiver** observations (predominantly mother–infant interactions)

- **Non-Western** communities have simultaneous multiple caregiving **without clear place-bound or time-bound task division** (Hrdy, 2011)

- Need to **assess** the **caregiver network’s sensitive responsiveness** to the infant **when simultaneous multiple caregiving** is the norm (Mesman et al., 2016)

  - **Being responded to sensitively** most of the time by many people **fosters trust in** the availability of the **entire network → secure attachment is to a system** rather than an individual
• Children and caregivers engage in **multiple, simultaneous, ongoing activities**
• Supports the cultural ideal of the **infant as an agent sensitized** to attend to others’ wishes and interests, and use these as the **primary referent of actions**
• Infant recognises the **specific other** as an **instance** of the **generic other** characteristic of the community
• This creates the ‘click’ – the **epistemic match**
Good caregiving is context dependent

- We cannot assume good caregiving is always and/or exclusively defined by sensitivity
- Cannot be defined adequately without reference to sociocultural context
- Depends on nature of this context
Recognising the role of the social context: A Copernican revolution?

- Family is **not** a closed system
- **Embedded** in community
Where attachment was there trust shall be...
Understanding the ‘p’ factor as an absence of expected resilience
From disease- to health-oriented research: A paradigm shift
Formerly: Investigating the mechanisms that lead to stress-related illness
Now: Investigating the mechanisms that protect against illness
Looking for the general psychopathology factor: Trauma or Resilience or Salutogenesis (Antonovsky & Sagy, 1986)

Social communication based capacity for learning and change
Persistent, impairing mental disorder
Severe SUD
Severe personality disorder
SEVERELY RESTRICTED SOCIAL LEARNING

Genetic liability
Early social adversity

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

Thomas S. Weisner, 2014
The theory of natural pedagogy and epistemic trust (Gergely & Csibra, 2008; Fonagy & Allison, 2014)

- New form of evolution (late Pleistocene) based on learning and the transmission of cultural knowledge
As soon as you need to create tools to make tools, the process of tool-making becomes distanced from its ultimate function, opaque in its intent and necessitates communication.
How do young humans learn to use the bewildering array of tools that surround them efficiently?
The theory of natural pedagogy and epistemic trust (Gergely & Csibra, 2008; Fonagy & Allison, 2014)

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

- New form of evolution (late Pleistocene) based on learning and the transmission of cultural knowledge

- The challenge of discerning of epistemic trustworthiness and the need for **EPISTEMIC VIGILANCE!**

- The pedagogic stance is triggered by **ostensive** communicative cues (E.G. turn-taking contingent reactivity, eye contact)

- Ostensive cues have **in common**
  - Person **recognized as a self**
  - Paid special attention to (noticed as an agent)
Triggering the Pedagogical Stance

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

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

Gergely, Egyed et al. (2013)

Subjects: 4 groups of 18-month-olds

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

Simple Object Request by Experimenter A

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

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

18-month-olds

Ostensive Expression - Generalization

Percent
Giving Positive Object

71
Non-Ostensive (Non-Communicative) Demonstration

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

18-month-olds

Ostensive Expression - Generalization

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

Demonstration Requester: SAME person
Learning from Attitude Expressions

18-month-olds

Ostensive Expression - Generalization

Non-Ostensive Expression - No Generalization

Non-Ostensive Expression - Person-Specific Attribution

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

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

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

- Feeling **contingently responded to** (**mentalized**) is the **quintessential ostensive cue** and therefore the **primary biological signal** that it is **safe to learn**
Attachment links to learning via epistemic trust

- We all have a **personal narrative**
- The **understanding** of that narrative by **another person** creates a **potential** for epistemic **trust**
- The **perception of the understanding** by the other of the personal narrative **generates epistemic trust**
- As it is a **perception** genuine understanding may not be necessary and the **illusion of understanding** may suffice.
Effective Ostensive Cue: Recognizing Agency

1. The learner's imagined self narrative

2. The instructor's image of the learner's self narrative

3. The learner's image of the instructor's image of the learner's self narrative

4. The epistemic match

5. Opening of epistemic channel for knowledge transfer
Individuals differ in the extent they are able to generate epistemic trust.
Individual Differences in Creating Epistemic Trust

• **Influential** communicators
  – use ostensive **cues** to **maximum**
  – create ‘**illusion**’ of recognizing agentiveness of listener
    • **Looking** at audience
    • **Addressing** current **concern**
    • Communicating that they see problem from **agent’s perspective**
    • Seeing and recognizing individual **struggle in understanding**

• **Massive difference in ability** of individuals to influence (teachers, politicians, managers, therapist) explicable in terms of varying capacity to **generate epistemic trust**
Meta-analytic studies of teacher effectiveness (Hattie, 2014)

• What makes a teacher the most effective?
  – It is teachers seeing learning through the eyes of students

• The key ingredients are:
  – Awareness of the learning intentions
  – Knowing when a student is successful
  – Having sufficient understanding of the student’s understanding
  – Know enough about the content to provide meaningful and challenging experiences

• Passion that reflects the thrills as well as awareness of the frustrations of learning.

With grateful thanks to Dr Peter Fuggle
Individuals differ in the extent they are able to experience epistemic trust.
Maltreatment and the failure of epistemic trust

- An abusive or neglectful caregiving environment (the child is not mentalized)
  - Ostensive cues are either absent or undermined by fear or confusion
  - Epistemic vigilance is not relaxed

- Epistemic mistrust (hypervigilance) develops
  - adults’ mind is not considered as a benign or reliable source of knowledge (deferential source – Sperber)
  - possible adult hatred, sadism, fear or indifference ➔ safer not to think about the caregiver’s mental states at all ➔ leads to failure to recognize when recognized
  - Oblivious to ostensive cues ➔ knowledge transfer blocked
Maltreatment and the failure of epistemic trust

- Once **epistemic trust is damaged** and the mind is partially **closed to** processing **new information**
  - access to exploring **different ways** of behaving and responding becomes **highly restricted**:
- The presentation of **fresh information cannot** be **internalized** as personally relevant or meaningful
  - Knowledge (including social knowledge) is **not updated** as it is **not trusted**
  - A subjective sense of **epistemic injustice** (being misunderstood) is **created** ➔ being ‘stuck in isolation’.
  - Impaired epistemic trust serves to severely **diminish** learning and therefore also responsiveness to **psychotherapeutic** intervention
Early maltreatment hinders associative learning

The world is not a rewarding place

- 41 adolescents exposed to childhood physical abuse
- 40 adolescents with no history of maltreatment

Hanson, JL., et al. (2017). *The Journal of Child Psychology and Psychiatry*
I hear you but I'm not listening.
In all 3 cases, the individual struggles to learn effectively about both self and others in the world.

Ostensive cues are not processed, were absent or misleading.

Learning channel is closed, indiscriminately open or both by turns.

Asocial caregiving /Dysfunctional communication environment

Absence of epistemic trust

Epistemic dilemma

Excessive credulity

Problems in learning from others

Problems in adapting to social world

Persistent epistemic mistrust and injustice

Insecure/disorganized attachment

Mentalizing difficulties \(\Rightarrow\) failure to identify being recognized
Reasons behind not experiencing trust

- Deprivation and trauma ➔ **chronic mistrust**
- Fear of mentalizing ➔ avoidance of mental state and
- Inadequate mentalizing ➔ misrepresent how others represent the person ➔ feel **persistently misunderstood** and experience intense and consistent **epistemic injustice**
- Inaccurate view of self ➔ perception of personal narrative in others does not experienced as a match
Reasons behind not experiencing trust

- Deprivation and trauma ➔ **inappropriate trust**
  - **self-representation too diffuse** ➔ **all things feels they fit**
  - **other’s representations of self** distorted ➔ creation of an **illusory fit** when none exists (I am accurately seen as bad)

- **Inaccurate view of self** (defensively generated – super-robust) ➔ **perception of personal narrative is calculated by informant to be experienced as a match by the learner (manipulation of the match)**
The nature of severe psychopathology

- Social adversity (most deeply trauma following neglect) is the destruction of trust in social knowledge of all kinds → rigidity, being hard to reach

- Cannot change because cannot accept new information as relevant (to generalize) to other social contexts

- Severe disorder is not disorder of personality but inaccessibility to cultural communication relevant to self from social context

  - Partner
  - Therapist
  - Teacher
  - Leader

  Epistemic Mistrust → Epistemic Injustice → Epistemic Isolation
Mentalization based definition of trauma

- Adversity becomes traumatic when it is compounded by a sense that **one’s mind is alone**: normally an accessible **other mind** provides the **social referencing** that enables us to frame a frightening and otherwise overwhelming experience.

Allen & Fonagy (2010)
Loneliness and Trauma

240 female Trauma
240 female HC

UCLA Loneliness Scale

a.

b.

counts

Loneliness
Building a social network in childhood and adolescence
When the capacity to form bonds of trust is shaky and tends to break down...
...we lose our learning network and social expectations (priors) are not updated
Implications: The nature of psychopathology

- **Epistemic mistrust** which can follow perceived experiences of maltreatment or abuse leads to **epistemic hunger** combined with **mistrust**

- **Persistent** severe disorder is a **failure of communication**
  - It is not a failure of the individual but a **failure of learning relationships** (patient is ‘hard to reach’)
  - It is associated with an **unbearable sense of isolation** in the patient generated by epistemic mistrust
  - Our inability to communicate with patient causes **frustration in us** and a tendency to **blame the victim**
  - We feel they are not listening but actually it is that they find it **hard to trust** the truth of what they hear
Implications for therapy
Therapist is greatest source of variance in psychotherapy outcome (Wampold et al. 2016)

Odds of a clinical episode in MBT by therapist.
Therapist is greatest source of variance in psychotherapy outcome (Wampold et al. 2016)

“In the beginner's mind there are many possibilities, but in the expert’s there are few”
Shunryu Suzuki
Revised model of psychological therapy

Patient creates a **self narrative** pertinent to **setting**

**Therapist** develops an **image of** patient’s imagined self **narrative**

**Patient detects** therapist’s narrative of patient’s self narrative

Patient makes a **match and epistemic trust** is generated

Therapist is in a **position to modify** enduring **understandings**

Patient’s **hope of epistemic trustworthiness** is changed
Reconceptualising severe persistent disorders in terms of communication failure...
...but as an absence of expected resilience or lack of epistemic trust...
Epistemic hypervigilance

Epistemic trust

High ‘P’ factor/ absence of expected resilience

Resilience/ low ‘P’ factor
Vulnerability to psychopathology...
...can be buttressed by foundations of epistemic trust that build resilience