When Is Truth Relevant?

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In the postmodern era, the relevance of the concept of truth, never a stress-free subject, has become a particularly vexed philosophical question. Along with other classical notions such as reason, identity and objectivity, the concept of truth has come to be regarded in some quarters with considerable suspicion. In part this suspicion is unescapable given the postmodern project's commitment to the exposure of the extent to which what is held to be knowledge or truth is determined by powerful interests. However, recognition that power and ideology do play an important role in determining what we call truth has often led to a thoroughgoing relativism and temptation to conclude that therefore 'anything goes'. As the cultural theorist Terry Eagleton has written, 'Against these Enlightenment norms, [postmodernity] sees the world as contingent, ungrounded, diverse, unstable, indeterminate, a set of disunified cultures or interpretations which breed a degree of scepticism about the objectivity of truth, history and norms, the givenness of natures and the coherence of identities.' (Eagleton, 1996).

Opponents of this kind of stance show a tendency to fall back to an absolutist position, fearing that 'Without defences against postmodern irony and cynicism, multiculturalism and relativism, we will all go to hell in a handbasket.' (Blackburn, 2005, p. xiii). The philosopher Simon Blackburn has suggested that this tendency to polarisation and conflict 'grumbles within the breast of each individual' as well as being manifest between people and groups, so it should not surprise us that the schism is rife also in psychoanalysis since it reflects a division within all of us. In a passing allusion to Wittgenstein's assertion that the proper job of philosophy is to provide a kind of therapy enabling us to correct fallacies of thought, Blackburn intriguingly frames this conflict as an immune deficiency:

> [This] conflict is about our conception of ourselves and our world, about the meaning of our sayings, and indeed the meaning of our activities and of our lives. It is about ideas that make up 'the spirit of the age', and that determine the atmosphere we breathe. If the ideas are inadequate or dangerous, then we need an immune system to protect us from them, and the only immunity would have to be conferred by better ideas. (p. xiv)

This paper will develop Blackburn's hint that at the level of the individual, the tendency to think in terms of a forced choice between commitment to the idea that there is a truth that can be revealed if one works hard enough and sceptical relativism is indicative of an immune deficiency or lack of resilience in the face of external impingement. We will explore the sociobiological relevance of the concept of truth as the primary qualifier of human communication which underpins the transmission of knowledge across generations, which in turn lies at the foundation of human evolution. Culture is the reservoir of knowledge accumulated and transmitted from one generation to the next and its preservation ensures individual adaptation and survival as well as the survival of social organizations; both are vulnerable to misleading and unreliable information. We will argue that thinking in terms of the forced choice Blackburn describes is an outcome of epistemic hypervigilance, a suspicion in relation to social influence that can prevent an individual from sufficiently trusting others to learn from them. In a clinical context, such hypervigilance is a major barrier to therapeutic change. In the context of a social movement (a collective of minds) such as psychoanalysis, the relativisation of truth can similarly serve as a protection from learning and the conferment of "better ideas". We will suggest that while the *experience* of knowing and having the truth about oneself known in the context of therapy is a necessary first step in bringing down this barrier, it should not be viewed as an end in itself but rather as the establishment of a stance that can drive learning about one's world.

The relativisation of truth

The philosophical debate on truth has been at the forefront of psychoanalytic discourse about therapeutic action for many years. On one hand there are those who characterise the experience of psychoanalysis in terms of its enabling of access to some sort of truth. Freud consistently formulated the purpose of psychoanalysis in terms of making the unconscious conscious (Freud, 1909)[Freud, 1933 #2530] and Grünbaum (1984) made it the acid test of psychoanalytic hypothetico-deductive hypotheses (Grünbaum, 2008). Many subsequent formulations have laid stress on the role played by analysis in replacing evasion of a frustrating reality with acceptance in order to be able to modify it (e.g. Bion, 1962a). David Bell [, 2009 #91] has suggested that 'All of us suffer from various kinds of epistemological malaise when it comes to facing certain unwanted aspects of reality' (p. 337); he characterises Freud along with Marx as critical thinkers seeking to expose the illusions we create and live by. Edna O'Shaughnessy (O'Shaughnessy, 1994) has defended the existence of scientific clinical facts, defining them as truths about the immediate emotional reality between analyst and patient.

However, thanks to the pluralism of modern psychoanalysis (Bernardi, 2005; Jimenez, 2008; Wallerstein, 1992) there is less clarity than there once was regarding the kinds of truths that psychoanalysis ought to be uncovering, and perhaps a further consequence of psychoanalytic pluralism is increasing scepticism about whether what is at stake is or should be the uncovering of truth at all. For example, Owen Renik [, 1998 #93] has argued that 'In order for us to develop a psychoanalytic theory that can direct us towards effective clinical practice […] it is crucial for us to relinquish any claim that an analyst in the treatment situation can be objective, in the positivist sense of the term, i.e. objective in a way that is significantly independent of subjective interests.' (p. 492). He goes on to state that 'Ethan [his patient] and I, in our investigation, were not trying to discover something that was

already there. We were trying to devise a view of Ethan's life, present and past, that *worked*, i.e. that helped him feel better. We evaluated the validity of our understanding entirely on the basis of its therapeutic efficacy (p. 492). ' The classical idea that the aim of analysis is or should be to discover truths about oneself has come to be associated with what Arnold Cooper [, 2003 #94]described as the 'intellectual reign of terror' of psychoanalytic orthodoxy in the US, the political aspect of which was exposed by the landmark lawsuit brought by a group of psychologists against the American Psychoanalytic Association and the IPA. The emotional strength of post-modern relativism and its intense intellectual pluralist sequelae are hard to comprehend without first-hand experience of the intermingling of intense mono-disciplinary dominance and theoretical absolutism of the preceding period.

In this context, relinquishing claims to objectivity on the part of the analyst can be read as the adoption of an ethical as well as an epistemological stance of openness. However, David Tuckett has argued that the resultant bewildering level of pluralism in psychoanalysis both within and beyond the IPA has been incompatible with 'many of the basic characteristics of modern professional regulation (Tuckett, 2003); including an environment of transparent scientific debate and professional quality control that makes it possible to attempt to compare and test the value of alternative theories and approaches in different clinical situations, and to state which ideas and practices are more or less beneficial and which are wrong' (Tuckett, 2005, p. 32). There has been resistance from various quarters to efforts to determine such standards, on the grounds that 'much of the formulation and maintenance of psychoanalytic standards is inherently a political process' (Renik, 2005, p. 61)). In effect, as we have demonstrated using bibliometric methods (Fonagy, 2003), citation statistics reveal an increasing fragmentation in our discipline; contributors appear willing to more or less ignore contemporary contributions other than from specific narrow orientations

siloed from one another cohering around a heroic period half a Century ago when object relations theory came to dominate psychoanalytic scholarship.

As our concern here is not the psychoanalytic movement but rather the individual patient's experience of truth, we should conclude this brief section on the relativisation of truth with a warning. Unwarranted certainty and its fundamental rejection may both be (in our language) non-mentalizing, or pre-mentalizing in character. We have described undue certainty about the veracity of an idea as *psychic equivalence* while a total repudiation of this certainty we denoted as *pretend mode*. Both are characteristic of a pre-mentalizing phase in the development of psychic reality (Fonagy & Target, 1996; Target & Fonagy, 1996). In our questionnaire measure of mentalizing we assess both excessive uncertainty and undue certainty as indicators of poor mentalizing (Fonagy et al., in press). In the current context it may be sufficient to say that if we see the global direction of therapeutic effort as the enhancement of mentalizing, both approaches to truth would be inimical to this purpose.

Truth as mental process (not mental representation)

A second, perhaps more fruitful development pertaining to the question of the relevance of truth in psychoanalysis has arisen from consideration of factors that prevent 'normal' neurotic functions such as repression and more generally the constitution of psychic reality from arising and operating stably. Although many psychoanalytic writers have considered this polarity, it is probably accurate to credit Wilfred Bion with bringing selective absence of specific mental capacities to the foreground of psychoanalytic theorising (Bion, 1959, 1962a, 1962b). Where Bion went, many followed, some explicitly acknowledging the links to Bion, others appearing more reluctant. For example, many years ago, scotomising our own indebtedness to Bion, we suggested that what we called disorders of mental representation could helpfully be distinguished from disorders of mental process (Fonagy,

Edgcumbe, Moran, Kennedy, & Target, 1993). Treatment of disorders of mental representation focuses on the mental mechanisms involved in the recovery of threatening ideas and feelings and the consequent reorganization of mental structures commonly invoked in explanations of psychoanalytic process.

The concept of disorders of mental process arose out of the experience of the psychoanalytic treatment of seriously disturbed patients. For example, a child who has been the victim of abuse may exclude from his mental activity *all* representations concerning the thoughts and feelings of his objects (Fonagy, 1998a). Forgoing thought about the mental state of others (what we came to refer to as mentalizing) may be the only means available to such a child to deal with the terror of contemplating his primary object's murderous wishes toward him. In this context, defensive avoidance of the 'truth' of an idea must be distinguished from defensive avoidance of the process of creating ideas (i.e. thinking) altogether. The aim of treatment in this latter case must be gradually to reactivate the inhibited mental process by elaborating the patient's preconscious mental content and giving them opportunities to explore the analyst's mental states in the context of the transference. Rather than seeking to restore access to a previously repudiated set of representations through interpretation, as in treatment of disorders of mental representation, what the analyst offers is in the Anna Freudian tradition of developmental help – not gratification or education, but scaffolding of the development of a capacity that has been defensively inhibited.

Truth, if relevant, rests in the reality of perceiving the object (self or other) as fully mentally functioning. The complement of truth, a lie, ie the deliberate manipulation of the belief states of an agent, paradoxically assumes a capacity to mentalize. To be able to detect falsehood therefore requires an even higher order capacity for representing the intention of the other as deceptive (understanding their intent to misrepresent in relation to one's own mind state). Given this complexity (third order theory of mind) it is unsurprising that we do

not normally calculate such complex intentions but rather aim to achieve a general subjective state of truth where an overarching experience of something being real and vital is created (see below).

Historical truth

Writing in the *International Journal of Psychoanalysis* in 1999, we clarified that while certain forms of psychopathology can be conceptualised as disorders of mental representation, the mental representations we deal with in psychoanalysis should not be simplistically equated with memories of past events. We suggested that

> The only way we can know what goes on in our patient's mind, what might have happened to them, is how they are with us in the transference. They come to us with a kind of model—a network of unconscious expectations or mental models of self–other relationships. Individual experiences that have contributed to this model may or may not be 'stored' elsewhere as discrete autobiographical memories, but in either case the model is now 'autonomous', no longer dependent on the experiences that have contributed to it. (Fonagy, 1999, p. 217).

We proposed that the key to therapeutic action lies in the conscious elaboration of preconscious relationship representations, principally through the analyst's attention to the transference, and that as a result change occurs in *implicit memory* leading to a change of the procedures the person uses in living with himself and with others. We argued that the recovery of memories in therapy is an epiphenomenon, a consequence rather than a cause of change.

This is not to say that truth is somehow 'embedded in the transference'. We stressed at the time that we were not claiming that attention to the transference opened a royal road to

understanding what had 'really' happened to the patient, noting (along the lines of Heinz Hartmann's [, 1955 #933] stress on the genetic fallacy) that the models patients come with 'are not replicas of actual experience but are undoubtedly defensively distorted by wishes and fantasies current at the time of the experience (p. xx)' However, Harold Blum's [, 2003 #6543] critique of the editorial read it as having presented transference as 'a literal recapitulation of the patient's early object relations' (p. 499). Blum argued that true knowledge of a patient's life history is a necessary corrective to the underlying conflicts and defensive compromise aspects of transference. Here we can see another version of the anxiety that without due attention to historical truth we might end up in a situation where 'anything goes' so that patient and analyst are caught up in a *folie àdeux*, no longer able to ground themselves through a connection with reality.

The emotional moment of truth

Whereas Blum took us to task for failure to attend to historical truth, another line of criticism which our mentalization-based theory of psychopathology and treatment faced was our perceived failure to attend to psychic truth. Our interest in severe disturbance and the impact of trauma, especially attachment trauma, and the resulting focus on forms of psychopathology that we conceptualised as disorders of mental process, has led to our theory being widely interpreted (not without some justification) as a deficit-focused model [e.g. \Kernberg, 2008 #98], essentially explaining patients' difficulties in terms of early environmental deficits (failure of marked mirroring) with the analyst offering him/herself as a new object providing the kind of corrective emotional experience for which Alexander and French [, 1946 #2926] received considerable (if undeserved) psychoanalytic approbation.

From this perspective the truth not properly attended to would be the unconscious conflicts that constitute the patient's psychic reality. The emphasis upon the (corrective)

emotional experience of the treatment as the essence of psychotherapy brings the emotional aspects of the treatment into the foreground, denies the centrality of insight and at least historically tended to incur the strong disapproval of the analytic community. 'Corrective emotional experience undeservedly became a synonym for superficial psychotherapy' (Wolf, 1992 p. 122).

Fortunately, the overvaluation of insight is behind us and the recognition of the importance of emotional truth (the felt truth of an experience) seems generally recognised as the key to therapeutic progress. The increasing influence of infant research may have been a key driver of this shift (Fonagy, 1998b). The slogan of the Boston Change Process Study group that *something more interpretation is needed* where that something takes the form of psychological acts of a mutative relationship with the therapist, embodies the intersubjective experience of truth around which a substantial consensus has now emerged (Boston Change Process Study Group, 2002, 2010). The BCPSG (2010) conclusively address this issue when speaking of 'now moments' as affectively charged '*moments of truth*' called kairos in ancient Greek—'the moment that must be seized if one is going to change his destiny, and if it is not seized, one's destiny will be changed anyway for not having seized it' (p. 42). What the BCPSG model fails to offer, compelling and unifying although it undoubtedly is, is a model of the psychological processes which may underpin the phenomenal experience of 'moments of meeting'. This intersubjective experience of bi-personal truth '… produces a feeling of vitalization, or increased well-being, because there is increased coherence of the dyadic system as a whole' (p. 89). and 'an upshot of fitting together is vitalization, experienced by both partners, which in turn leads to a greater feeling of liking each other. This vitalization serves as a directional element, in that it encourages the two to repeat ways of being together that generate such inner experiences, thus being a hallmark of dyadic quality' (p. 210).

Predictably there has been scholarly opposition from 'vested interests' to such a comprehensive redesign of the analytic process (e.g. Ellman & Moskowitz, 2008; Ryle, 2003). The doubt emerges not principally from uncertainty about the emotional reality of such moments of truth but reservation about the limited emphasis given to language and cognition in bringing about the implicit relational knowing. BCPSG's emphasis is on relational knowing being automatically or implicitly updated in small ways with each encounter leading to an accumulation of small changes creating subtle shifts in organizations that ultimately influence behaviour outside the treatment situation. However, this appears to leave the bulk of the analytic process in the realm of the superfluous. Elsewhere, we have, in the spirit of BCPSG, also suggested that unconscious evocation of meaning encoded in vocal gestures through intonation, stress and other paralinguistic aspects of the encounter can carry interpersonal messages (Fonagy & Target, 2007b). But such suggestions of unconscious communication, while clearly important and undoubtedly intriguing, cannot be allowed conceptually to override the mainstream of verbal communication which provides the backbone of the therapeutic encounter. While for the most part probably unintentionally, a focus on the implicit can raise it hierarchically above the explicit in importance, somehow closer to the 'truth' for which there is no genuine indication and the accompanying theorisation is imprecise at best.

Mentalizing and the feeling of truth

From its inception psychoanalysis set out to show the patient something about himself that he had not previously (consciously) known: to make the unconscious conscious. The purpose of this, it should be noted, was not the acquisition of intellectual insight but had the pragmatic goal of bringing about change: enabling the patient to live differently, freeing him or her to love and work or, less ambitiously, exchanging neurotic misery for common unhappiness (Freud, 1893). As Freud rapidly discovered, powerful forces within the patient

militate against acquiring such knowledge. The analyst must find a way of helping the patient to hear the interpretations s/he offers: if s/he intervenes without regard for the patient's defences, the interpretation, however accurate, is likely to fall on deaf ears.

Our theories of borderline psychopathology and treatment have focused around the capacity for mentalization (Fonagy, Gergely, Jurist, & Target, 2002). We have come to view mentalization, that is, the ability to interpret both our own and other people's behaviour in terms of underlying thoughts, feelings and wishes, as a multidimensional capacity that is acquired in the context of attachment relationships and is less securely established in individuals who for a variety of reasons have had only limited opportunity to learn about their minds in their early relationships with their caregivers (Fonagy & Target, 1996; Target & Fonagy, 1996). This has often been the case in individuals with adult diagnoses of borderline personality disorder (Fonagy & Target, 2000). In situations of interpersonal stress, such as may occur for example in the context of attachment relationships, the capacity of these individuals to mentalize is impaired, allowing developmentally earlier modes of thinking to (re)emerge. This poses a problem for the therapist, since the vicissitudes of the relationship established with the patient are highly likely to make it difficult for the patient to keep mentalizing online (Fonagy & Target, 2007a). Once this happens, no matter how true or accurate the interpretations the therapist might wish to offer are, the patient will not be able to make use of them because they are not experienced as true and are regarded with suspicion (Fonagy & Allison, 2014a).

The solution we have advocated is a technique that strives to scaffold and facilitate the development of the patient's capacity to mentalize by focusing therapeutic attention on validating, clarifying, sometimes challenging and elaborating on the mental state perspectives adopted by the patient (Bateman & Fonagy, 2010). The patient's experience of the therapist is a crucial focus of the work. Notwithstanding the impression we may have given in our

earlier work, this is not undertaken principally in order to enable the patient to understand himself better, although this may be an outcome, nor to help him understand his relationship with the therapist better, although this almost inevitably happens as part of the process. Rather, the aim is to equip the patient with the tools to negotiate his current and future relationships more successfully. We have come to think of mentalizing as a key to understanding resilience (Fonagy, Steele, Steele, Higgitt, & Target, 1994), and we now also prefer to conceptualise the characteristic difficulties with mentalizing shown by patients with borderline personality disorder not as a deficit but as a useful adaptation (Fonagy, Luyten, & Allison, 2015a). While in this context it may appear that we have reverted to a relativist view, where regaining the capacity to mentalize alone matters and the way that this is achieved is no longer the point, in the phenomenal experience of our patients, mentalizing is linked to an experience of 'truth', of the kind of sense of presence, vitality and at oneness with oneself and the social world which the BCPSG have also so eloquently described.

In other words, we see mentalizing as marked by an intersubjective experience where two individuals feel the psychological presence of the other and the relationship between them feels real (not pretend or absent) and in that sense genuine and true. We all know the feeling of discourse with patients that is lacking this quality of vitality, when the impact of one's words fail to resonate with the patients and when we struggle to achieve genuine understanding of the his/her apparently earnest discourse. In such communication there is no genuine mentalizing. When this starts, metaphorically speaking, the patient suddenly appears in the room. We are talking to them and our words clearly make an impact. Call this a moment of meeting if you like but such 'moments' can stretch into minutes and perhaps entire sessions (although this in our experience is rare – about five minutes is the modal length of mentalizing discourse). The risk is the illusion we are well able to create for ourselves that our mentalizing the patient is sufficient. Yet at our most 'mentalizing' we

create an illusion, a pretence of mentalizing which is so self-satisfying because it is compensating for the absence of mentalizing of our social (conversational) partner – our patient. We pseudo-mentalize (Fonagy & Luyten, 2009) or hypermentalize (Sharp et al., 2011), create complex an unrealistic pictures of internal worlds, precisely because the person we are talking to has given up trying to find a genuine mental connection. In our experience this is a genuine clinical risk and the root cause of many a long analysis. In brief, using mental state language is not tantamount to mentalizing or truth. The connection (or borrowing Tronick's phrase, co-consciousness) via genuine mutual sharing of mental state understanding generates the felt experience of truth (Fonagy, 2015b; Tronick, 2007).

Personal truth and epistemic trust

The experience of mutual sharing leading to the experience of truth or sense of realness may have a profoundly important biological underpinning which we will now turn to explore. A straightforward link between truth and trust in the reliability of knowledge could be via the biologically overdetermined mechanism of attachment relationship. As described above, the sense of mutual understanding underpinned by mentalizing, we have suggested, is born of the dyadic connection between caregiver and child. The capacity to envision mental states in others grows out of a process of self-understanding which in turn depends on the other's capacity to perceive the self as thinking and feeling (Sharp & Fonagy, 2008). A secure caregiver-child relationship would be expected to facilitate this virtuous cycle, particularly as the security of the relationship is enhanced by the caregiver's capacity to mentalize the child (Berthelot et al., 2015; Ensink, Berthelot, Bernazzani, Normandin, & Fonagy, 2014; Fonagy & Target, 2005). Thus, to the extent that truth and mentalizing are linked in the experience of mutual understanding, secure attachment could almost be seen as coterminous with the experience of truth or at least as a key route towards this experience.

Recently we have begun to view our earlier formulations of the mentalizing model of BPD as primarily mediated by attachment history as perhaps overly narrow, and attachment as a construct as perhaps somewhat limited from a developmental psychopathology standpoint (Fonagy & Campbell, in press). Previously, along with others (Gunderson, 1996), we placed considerable weight on role of attachment disorganization in our accounts of the disorder (Fonagy, Target, & Gergely, 2000). We would here like to suggest that a broader perspective is necessary which places the notion of truth experience and mentalizing in a broader biological context of social communication that guides the infant to prioritize developing particular capacities and behaviours in order to maximise their chances of survival. This line of thinking, grounded in Gergely and Csibra's theory of natural pedagogy (Csibra & Gergely, 2006, 2009, 2011; Hernik & Gergely, 2015; Kiraly, Csibra, & Gergely, 2013), takes as its starting psoint the relative helplessness and dependence of the human infant born into a cultural world of bewildering complexity where acquiring information from knowledgeable adults is crucial for continued existence. In this situation, in order to survive, the human infant must learn fast, and he relies on his caregivers to facilitate this process.

A new form of human natural selection (arguably dating back to the late Pleistocene) is based on socially mediated learning and the transmission of cultural knowledge is introduced which contrasts with Darwinian evolution based on genetic transmission passed on from one generation to the next (Wilson & Wilson, 2007). Co-evolution of gene and learning-based forms of natural selection applies to human cultures as well as individuals. The selective transmission of knowledge primarily adaptive at the group level will enable human cultural diversity to be studied in the same way as biological diversity (Wilson, 2013), making the process of the interpersonal transfer of information via communication from one generation to the next perhaps the key biological function of development.

There are two possible bases on which a learner can accept cultural knowledge as true: they can either work it out for themselves (which is time-consuming and difficult, often impossible) or trust in the communicator's authority (Wilson & Sperber, 2012)(Sperber et al., 2010). Trusting the communicator means that the learner does not have to go back to first principles each time they encounter novelty: a strange-looking tool without a self-evident purpose is accepted as being used as described by the trusted elder (Recanati, 1997). Faith in such information is critical. The potential for being misled by false (untrue) information by unreliable, uninformed, or downright malevolent providers of useless or deceiving information is omnipresent for the young human. We will refer to the trust required for social learning as *epistemic trust*. The capacity to teach and learn social knowledge underpins the evolution of human culture (Wilson, 1976).

Trust involves exposing oneself to the risk of being misled, perhaps dangerously. It is adaptive for humans to adopt a position of epistemic vigilance unless they are reassured otherwise (Recanati, 1997; Sperber et al., 2010). Children are not promiscuously credulous to those around them; there is evidence that dubious social signifiers and poor past performance may render a social communicator suspect, leading their assertions about the world to be regarded sceptically (Brousseau-Liard, Cassels, & Birch, 2014; Durkin & Shafto, 2016; Koenig & Harris, 2005). What is it that enables the infant to determine who is worthy of trust, which is necessary for their vigilance to be relaxed enough to allow them to encode the social knowledge they are being offered as significant, relevant to them personally and socially generalizable?

The key signals that allow this kind of learning to take place are the communicator's *ostensive cues* (Csibra & Gergely, 2009) (an inspired suggestion based on Bertrand Russell, 1940): signals used by an agent to alert the addressee that the agent intends to communicate relevant pieces of cultural knowledge. Ostensive cues for infants include eye contact, turn-

taking contingent reactivity, and the use of a special vocal tone ('motherese'), all of which appear to trigger a special mode of learning in the infant. Ostensive communicative cues, such as being called by name, trigger the *pedagogic stance* (Csibra & Gergely, 2009). By using ostensive cues—both in childhood and in adulthood—the communicator explicitly recognizes the listener as a person with intentionality. When the infant is paid special attention to and noticed as an agent, he/she adopts an attitude of epistemic trust and is thus ready to receive personally relevant knowledge about the social world that goes beyond the situationally specific experience. In this way knowledge is acquired that is relevant in many settings. The subjective experience of relevance and a judgement of truth thus crucially depends on having been made to feel agentive by the communicator. We can conceptualise the 'moments of meeting' emphasized by the BPCSG as an experience of agency in the listener associated with a sense of feeling recognized which then opens a biologically prepared pathway to receive and internalize information to be incorporated into existing structures and to be used (without reference to the communicator) as true information.

The link to mentalization is of course via the creation of a sense of agency (linking further to Max Weber's notions of socialisation Giddens, 2013). The experience of truthful communication then, to some measure at least, depends on the interpersonal context where the communicator is able to demonstrate awareness of the recipient's intentionality, which in turn generates trust and an expectation of truthfulness and personal relevance. This then ensures the incorporation of new information into existing knowledge structures. Mentalizing the recipient thus serves as an ostensive cue. If my perspective is recognized by the communicator then there must be truth in what I have heard. It is not that I do not understand what I am told without the ostensive cue but I would not consider the information relevant to me. I remember it, I can even repeat it, but I do not genuinely believe it. I do not consider it *personally true*. I could establish its truth value via working it out from first principles. But,

as we have said, that is quite hard work. What makes a teacher effective? It is being able to see and respond to the learning challenge from the student's perspective (Hattie, 2013).

Resisting truth and epistemic hypervigilance

In normal circumstances, epistemic trust develops in the context of attachment relationships. Secure attachment relationships in infancy provide the most consistent contingent parental responses to the child, thus also the most consistent ostensive cueing, creating fertile ground for epistemic trust to emerge. In situations where the young learner's early environment is heavily populated by unreliable communicators, the opening of epistemic trust becomes problematic. It may be more adaptive to remain persistently vigilant about, or even closed off to, the communication of social knowledge. In the face of an abusive and hostile caregiver, whose intentions towards the infant or child are not benign, epistemic mistrust may be a more appropriate adaptation.

Epistemic hypervigilance can manifest as the over-interpretation of motives, which can take the form of hypermentalizing (Sharp et al., 2013; Sharp et al., 2011), or pseudomentalizing (Asen & Fonagy, 2012). In this state of mind, the recipient of communication assumes that the communicator's intentions are other than those declared and therefore not treated as though from a *deferential source*. The truth of the message is resisted. Most typically, epistemic mistrust manifests as the misattribution of intention and the assumption of malevolent motives behind another person's actions, and therefore treating them with epistemic hypervigilance (or conversely, in some instances, excessive inappropriate epistemic trust). There is some evidence to suggest that a hypermentalizing stance is more characteristic of BPD in adolescence (Sharp et al., 2013)(Sharp et al., 2011). It is possible that this hypermentalizing typically subsides into a flatter profile of outright epistemic mistrust as the individual matures. This pattern, we speculate, may partially

account for the common life course history of BPD symptoms which sees a reduction in impulsive symptoms over time, but no lessening of the affective and social symptoms associated with BPD.

In a state of epistemic mistrust, the recipient of social communication may well understand what is being expressed to him/her, *but he/she cannot encode it as truthful*, as relevant to her/his experience, to internalize it and appropriately reapply it. Even when evidence is available to suggest that the person's expectations may be ill founded, that important figures are loving and caring rather than hostile and malevolent, the evidence will be rejected as false and mistrust will continue to dominate. There is considerable stability associated with this mind state; the persistence is embedded in the resistance to potential alternative perspectives, to possible truths. A person in a state of epistemic mistrust has a compromised capacity for appropriately interpreting social actions in terms of mental states which normally bolsters a sense of resilience, leaving the individual with dysfunctional social learning systems inadequate to assure adaptation in the face of change or 'normal' adversity. They see betrayal everywhere. Almost all communication may be contaminated by a sense of falseness and hypocrisy. The pervasive sense of expected inauthenticity creates a resistance to communication, the inbuilt natural system of epistemic vigilance becomes hyperactive; in a strange analogy with the immune system which attacks and rejects transplanted organs it identifies as foreign to the system, normal epistemic vigilance becomes overactive and labels all new information as inauthentic. This creates the epistemic petrification typical of persistent conditions (Fonagy, Luyten, & Allison, 2015b). The regular process of modifying one's stable beliefs about the world in response to social communication has been closed down or disrupted.

This generates the quality of rigidity and creates an impression of being 'hard to reach' that therapists have often described in their work in the field of PD (Fonagy et al.,

2015a). Change cannot be made because although the patient can hear and understand the social communication transmitted by the therapist, this new information cannot be accepted *as true for them* (i.e. relevant to them) and therefore potentially helpful in other social contexts. The persistent distress and social dysfunction associated with PDs is the result of the destruction of the truthfulness of social knowledge of most kinds. Personality disorder, therefore, may be best understood as a failure of communication arising from a breakdown in the capacity to forge learning relationships where knowledge about oneself and one's relationships may be modified by new knowledge. It is, we believe, this quality that underlies the painful sense of isolation that characterizes the subjective experience of a patient with PD.

Discovering social truths through forging epistemic trust

Notwithstanding the 'hard to reach' quality of patients with PD referred to above, treatments have been shown to be effective as evidenced by clinical reports and formal RCTs (Bateman & Fonagy, 1999; Clarkin, Fonagy, & Gabbard, 2010; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Doering et al., 2010) (Gunderson & Links, 2014; Jørgensen et al., 2014; Jorgensen et al., 2013; McMain, Guimond, Streiner, Cardish, & Links, 2012; McMain et al., 2009). But this is <u>not</u> an example of relativisms. Although many things appear to work, it is by no means the case that anything does. In fact in many of the trials it is treatment as usual (often by experts) which appears to fail relative to better-structured somewhat programmatic approaches where treatment manuals provide the therapists with clear directions as to what to say and when. How can we account for this? Rather than invoking a content-free common factor – even one as appealing as mentalizing – we answer this question in terms of the structural features that these treatments share. Pertinently to the current context, our speculations link the comparable effectiveness of a diverse range of interventions to the felt truth experience of individuals treated in these therapies.

Elsewhere we have suggested that effective treatments of BPD all involve the sequential implementation of three communication systems relating to the concepts of epistemic trust and social learning (Fonagy & Allison, 2014b). If psychopathology can be accounted for in terms of an underlying structure of epistemic mistrust in truth and personal relevance, this implies that the common aim of treatment must be to facilitate the emergence of epistemic trust and felt truth in order to allow social learning (or learning from experience) once again to take place.

The initial step towards change involves communicating knowledge that indicates to the patient that the therapist may be a valuable source of information. All evidence based models of therapy for persistent disorders present models of mind, disorder and change that are accurate, helpful to patients and increase capacity for understanding. The therapist's attempt to apply his model to the patient requires him to work collaboratively with the patient, to see the patient's difficulties from the patient's perspective, and to assume that s/he has things to teach the therapist. In these ways the patient's agency is recognised, and knowledge that is felt as relevant serves as an *ostensive cue* that allows patients to move towards reducing their epistemic hypervigilance. The therapeutic model provides explanations that feel relevant to the patient and generate moments of meeting or moments of truth. We do not see these moments as relevant for the insight they provide but the felt truth they generate serves to move the patient closer to the therapist and deepens the patient's interest in the therapist's thoughts and perhaps even feelings.

This moves the treatment to a second step within the change process: the increase in mutual understanding (i.e. increasing the robustness of mentalizing in the patient). The therapist's focus on the patient, their theory-driven attempt to understand their actions, invariably involves mentalizing. By mentalizing the patient effectively, the therapist models mentalization, creates an open and trustworthy environment, lowers emotional arousal and

makes it possible for the patient to exercise their growing curiosity about the therapist's thoughts about them. A process of communication is rekindled characterized by the increasing frequency with which their communication is accompanied by the experience of felt truth. In this process the therapist recognises the patient as an agent, acknowledges and helps the patient to identify his/her emotional states (a form of marking), and makes extensive use of ostensive cues to indicate the personal relevance and generalizability of what is being communicated. As the therapist models mentalization the patient's inhibition or habitual disuse of this capacity is shifted and mentalizing is starts to be available to support the patient's learning from social experience.

Mentalizing in this context is not an end in itself. Mentalizing is the catalyst that activates the effective ingredient of therapy: learning from experience. Mentalizing moderates the impact of communication because ostensive cues of the therapist and others are frequently erroneously interpreted by a poorly mentalizing individual and epistemic trust is not established. With improved mentalizing the communication of the therapist is better appreciated and accurately interpreted as to be trusted and has the intended influence on the patient, who can begin to put it into practice, at first within and then beyond the therapeutic context. The mentalizing stance recommended in mentalization based treatment (MBT) optimises the opportunity to regenerate epistemic trust through nonjudgmental inquisitiveness, curiosity, open-mindedness, uncertainty, not-knowing, and interest in understanding better (Allen, Fonagy, & Bateman, 2008). What mentalizing brings to clinical impact is not linked to improved access to the truth of understanding the inner world. Mentalizing is helpful because it generates enriched appreciation of ostensive cuing, which in turn generates greater access to accurate and true social knowledge, allowing the patient to internalize new knowledge and modify social appraisal, expectations and behaviour accordingly.

The greatest benefit from a therapeutic experience comes from generalizing epistemic trust beyond therapy such that the patient can continue to learn and grow from the relatively undistorted truth encountered in relationships external to the therapeutic. Social learning in the context of epistemic trust occurs once again in the 'real world'. The person's mind is opened to the truths they previously resisted via the establishment of epistemic trust (collaboration) that enables him/her once again to trust the social world. Thus, it is not just what is taught in therapy that teaches, but the evolutionary capacity for learning from social situation that is rekindled. Enhanced mentalizing improves social relationships and enables the individual to recognize who is a reliable and trustworthy source of information, who one's *true friends* are; learning who I can be 'friends with' is key.

The improved epistemic trust and abandonment of rigidity enables the person to begin to learn from experience once again. So change is probably due to how a person comes to use their social environment, not the truth of what is specifically discovered in therapy. The benefits of therapy remain contingent on what is accessible to patients in their particular social world. Therapy interventions are effective because they open the person to social learning experience which feeds back in a virtuous cycle. If the environment is at least partly benign therapy will 'work'; social support, chronicity, complexity and intensity are the best predictors of therapeutic success (Fonagy, 2015a). If the truth that the lifting of epistemic hypervigilance uncovers is unremitting hostility and the absence of benign influence, the recovery of epistemic trust through therapy will generate no lasting improvement and may even lead to deterioration.

The social context of truth

This third step - social learning in the context of epistemic trust – is the mechanism, according to our thinking, at work in the circular and self-perpetuating relationship between

PD and the social context. The conceptualization of the three steps in a communication system involves an acknowledgment of the inherent limitations of clinical interventions in cases where the patient is faced with a wider social environment which does not support mentalizing. The implication of this is that what happens within any therapeutic intervention cannot, on its own, be expected to be enough for any lasting significant improvement in the patient's state to occur. And indeed, certain circumstances make it maladaptive for the individual to develop epistemic trust – to lower their social defences - in social environments characterized by high levels of aggression or violence which prioritizes an external, non-reflective rapidly responding affective focus on others as opposed to the self.

While the epistemic mistrust of an individual with a history of trauma and PD symptomatology may be an understandable defensive adaptation, the philosophical tendency to veer between a dogmatic conception of truth and unresolvable scepticism can perhaps be seen as manifestations of a principled refusal to adopt the pedagogic stance: to the philosopher, truth cannot be guaranteed if it is learned from others but the problem is then that it becomes very difficult to find a way of guaranteeing it at all. For example, the sceptical philosopher David Hume rapidly found that in his attempts to study causation what he identified over and over again was the role played by custom and habit in determining us to adopt the beliefs that guide us as truths. He described the quandary this placed him in as a 'philosophical melancholy and delirium' and characterised his experience of dismay in terms of painful social isolation:

> I am first affrighted and confounded with that forlorn solitude, in which I am plac'd in my philosophy, and fancy myself some strange uncouth monster, who not being able to mingle and unite in society, has been expell'd all human commerce, and left utterly abandon'd and disconsolate. (Hume, 1739)

Hume's preferred remedy for this distress was twofold: to remind himself that as a true sceptic he ought to be diffident of his philosophical doubts (recognizing them as indicating something about his mental states rather than knowledge about the world), and to allow the experience of a social environment to have a therapeutic effect on him:

> I dine, I play a game of back-gammon, I converse, and am merry with my friends; and when after three or four hour's amusement, I wou'd return to these speculations, they appear so cold, and strain'd, and ridiculous, that I cannot find in my heart to enter into them any further.

We have seen that anxieties on the one hand about authoritarianism masquerading as truth and on the other about a worrying epistemological and by implication moral relativism are also characteristic of psychoanalytic discourse. Those who have laid stress on the need to face the truth (about oneself, about one's relationships, about reality) tend to frame this as a safeguard against collusion between analyst and patient. Conversely, those who have argued that psychoanalysis does not aim 'to discover something that was already there' see those who privilege achievement of increased self-awareness as in danger of becoming proselytisers: only working with the small subgroup of potential patients who would like to become analysts themselves. What these two positions have in common is discomfort with the idea that psychoanalysis might involve any form of deferential knowledge transmission. The spectre of suggestion continues to haunt psychoanalysis. As many commentators have noted, the discipline's focus on individual psychology has prevented analysts from thinking systematically about groups and social systems, despite Freud's insistence that '[I]n the individual's mental life someone else is invariably involved, as a model, as an object, as a helper, as an opponent, and so from the very first Individual Psychology is at the same time Social Psychology as well—in this extended but entirely justifiable sense of the words'.

It is worth stressing the point that while the theory of natural pedagogy emphasises the vital role played by transgenerational transmission of knowledge in the development of human culture; ostensive cues are necessary in order for the channel for knowledge transmission to open. It is not the case that humans will uncritically accept whatever they are offered. When we are offered pieces of social information, we experience as true what we find relevant and useful. In infancy, contingent, marked mirroring that involves recognition of the child's subjectivity and agency is experienced as helpfully naming and organising the child's constitutional self-states, facilitating the regulation of affect and disposing him or her to learn about social cognition (Gergely & Watson, 1996). Learning about ourselves in the interaction with the caregiver prepares us and equips us with the tools we will need to acquire this complex body of social knowledge. If we are not assisted in this way to take ownership of the knowledge we are offered we are unlikely to be able to hold on to it and make use of it in new situations.

Similarly, in therapy, the experience of the therapist having the patient's mind in mind and helping them to make better sense of what they do in terms of underlying thoughts and feelings is a vital preliminary step on the road to beginning to do things differently. If what the therapist offers in this respect is not felt to be true, the channel for knowledge transmission will remain closed and the patient will be unable to learn from the experience of therapy. *Experienced or felt truth is relevant not as an end in itself but as an ostensive cue allowing the patient to begin to take ownership of and use the social knowledge they are being offered both within and beyond the consulting room.* The experience of attention to, understanding of and respect for the individual psyche is essential to prepare us for the complexities of interaction in the large social groups that are characteristic of humankind, and from this perspective individual psychology is indeed group psychology as well. While the experience of knowing and having the truth about oneself known is not an end in itself, it is

critical in enabling us to establish epistemic trust and build the mentalizing capacity that will enable us to navigate the choppy waters of social interaction successfully.

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