WHEN IS TRUTH RELEVANT?

BY ELIZABETH ALLISON AND PETER FONAGY

The authors argue that the experience *of knowing and having the truth about oneself known in the context of therapy is not an end in itself; rather, it is important because the trust engendered by this experience (epistemic trust or trust in new knowledge) opens one up to learning about one's social world and finding better ways to live in it. The authors consider the consequences of a lack of epistemic trust in terms of psychopathology.*

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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 inescapable, 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."

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As cultural theorist Terry Eagleton (1996) wrote:

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. [p. vii]

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," in Simon Blackburn's words (2005, p. xiii). Blackburn, a philosopher, suggested that this tendency toward polarization and conflict "grumbles within the breast of each individual" (p. xiv), as well as being manifest between individuals 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. [2005, 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, on the one hand, and skeptical relativism, on the other, 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

that 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 relativization of truth can similarly serve as a protection against 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 RELATIVIZATION 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 characterize the experience of psychoanalysis in terms of its enabling of access to some sort of truth. Freud (1909, 1933) consistently formulated the purpose of psychoanalysis in terms of making the unconscious conscious, and Grünbaum (1984, 2008) made it the acid test of psychoanalytic hypothetico-deductive hypotheses.

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). Bell (2009) 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 characterizes both Freud and Karl Marx as critical thinkers seeking to expose the illusions we create and live by. O'Shaughnessy (1994) 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 skepticism about whether what is at stake is or should be the uncovering of truth at all. For example, Renik (1998) 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 went 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, italics in original]

The classical idea that the aim of analysis is or should be to discover truths about oneself has come to be associated with what Cooper described as the "intellectual reign of terror" (2003, p. 112) of psychoanalytic orthodoxy in the United States. The political aspect of this was exposed by the landmark lawsuit brought by a group of psychologists against the American Psychoanalytic Association and the International Psychoanalytical Association. The emotional strength of postmodern relativism and its intense intellectual pluralist sequelae are hard to comprehend without firsthand experience of the intermingling of intense monodisciplinary 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, Tuckett (2005) argued that the re-

sultant 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, . . . 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. [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 those 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 relativization of truth with a warning. Both unwarranted certainty and its fundamental rejection may be (in our language) nonmentalizing or prementalizing 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 prementalizing phase in the development of psychic reality (Fonagy and Target 1996; Target and Fonagy 1996).

In our questionnaire measure of mentalizing, we assess both excessive uncertainty and undue certainty as indicators of poor mentalizing (Fonagy, Luyten 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 Bion (1959, 1962a, 1962b) with bringing selective absence of specific mental capacities to the foreground of psychoanalytic theorizing. Where Bion went, many followed—some explicitly acknowledging links to Bion, others appearing more reluctant to do so.

For example, many years ago, scotomizing 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 et al. 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 have come 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 the latter case must be to gradually reactivate the inhibited mental process by elaborating the patient's preconscious mental content and giving him 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—i.e., 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 his 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; rather, we aim to achieve a general, subjective state of truth in which an overarching experience of something as real and vital is created (see the section that follows).

HISTORICAL TRUTH

Previously, we clarified that, while certain forms of psychopathology can be conceptualized as disorders of mental representation, the mental representations we deal with in psychoanalysis should not be simplistically equated with memories of past events (Fonagy 1999). It was 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. [p. 217]

The key to therapeutic action, it was proposed, lies in the conscious elaboration of preconscious relationship representations, principally

through the analyst's attention to the transference. 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. It was 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. Fonagy (1999) stressed that no claim was being made that attention to the transference opened a royal road to understanding what had "really" happened to the patient. It was noted (along the lines of Hartmann's [1955] 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" (Fonagy 1999, p. 217).

However, Blum's (2003) critique of this position 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 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 à deux,* no longer able to ground themselves through a connection with reality.

THE EMOTIONAL MOMENT OF TRUTH

Whereas Blum (2003) took Fonagy (1999) to task for failure to attend to historical truth, another line of criticism that the mentalization-based theory of psychopathology and treatment has faced was its perceived failure to attend to psychic truth. Our interest in severe disturbance and the impact of trauma, especially attachment trauma, as well as the resulting focus on forms of psychopathology that we conceptualized 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 et al. 2008)—essentially explaining patients' difficulties in terms of early environmental deficits (failure of marked mirroring), with the analyst offering himself as a new object: one who provides the kind of cor-

rective emotional experience for which Alexander and French (1946) 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—has 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 importance of emotional truth (the felt truth of an experience) seems generally recognized as the key to therapeutic progress. The increasing influence of data from 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 than interpretation* is needed, where that something takes the form of psychological acts within 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 conclusively addressed 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" (2010, p. 42).

What the BCPSG model—compelling and unifying although it undoubtedly is—fails to offer is a model of the psychological processes that 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. [2010, p. 210]

Predictably, there has been scholarly opposition—from so-called vested interests—to such a comprehensive redesign of the analytic process (e.g., Ellman and Moskowitz 2008; Ryle 2003). Doubt emerges not principally from uncertainty about the emotional reality of such moments of truth, but from reservations about the limited emphasis given to language and cognition in bringing about implicit relational knowing. The BCPSG's emphasis is on relational knowing as automatically or implicitly updated in small ways, with each encounter leading to an accumulation of small changes that create subtle shifts in organizations; these shifts ultimately influence behavior outside the treatment situation. However, this appears to leave the bulk of the analytic process in the realm of the superfluous.

Elsewhere (Fonagy and Target 2007b), in the spirit of BCPSG, we have suggested that unconscious evocation of meaning encoded in vocal gestures through intonation, stress, and other paralinguistic aspects of the encounter can carry interpersonal messages. But such suggestions of unconscious communication, while clearly important and undoubtedly intriguing, cannot be allowed to conceptually override the mainstream of verbal communication that provides the backbone of the therapeutic encounter. While for the most part it is probably unintentional, 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 theorization 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; instead, it had the pragmatic goal of bringing about change: enabling the patient to live differently, freeing him to love and work—or, less ambitiously, exchanging neurotic misery for common unhappiness (Breuer and Freud 1895). As Freud rapidly discovered, powerful forces within the patient militate against acquiring such knowledge. The analyst must find a way of helping the

patient hear the interpretations offered. If the analyst intervenes without regard for the patient's defenses, 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 et al. 2002). We have come to view mentalization—that is, the ability to interpret both our own and other people's behavior in terms of underlying thoughts, feelings, and wishes—as a multidimensional capacity that is acquired in the context of attachment relationships. It 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 caregivers (Fonagy and Target 1996; Target and Fonagy 1996). This has often been the case in individuals with adult diagnoses of borderline personality disorder (Fonagy and 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 quite likely to make it difficult for the patient to keep mentalizing online (Fonagy and Target 2007a). Once the patient stops mentalizing, no matter how true or accurate the therapist's interpretations 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 and Allison 2014).

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 and Fonagy 2010). The patient's experience of the therapist is a crucial focus of the work. Notwithstanding the impression that might have been 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—or to help him better understand his relationship with the therapist, 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 et al. 1994), and we now prefer to conceptualize the characteristic difficulties with mentalizing shown by patients with borderline personality disorder not as a deficit, but as a useful adaptation (Fonagy, Luyten, and Allison 2015). 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 that the BCPSG have also so eloquently described.

In other words, we see mentalizing as marked by an intersubjective experience in which 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 patient, and when we struggle to achieve genuine understanding of his apparently earnest discourse. In such communication, there is no genuine mentalizing. But when mentalization begins, the patient suddenly appears in the room, metaphorically speaking. The analyst is talking to him and the analyst's 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, in our experience, this 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 pretense of mentalizing that is so self-satisfying because it compensates for the absence of the mentalizing of our social (conversational) partner—our patient. We pseudomentalize (Fonagy and Luyten 2009) or hypermentalize (Sharp, Pane et al. 2011); we create complex and 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 [2007] term, *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 that we will now turn to exploring. A straightforward link between truth and trust in the reliability of knowledge may exist via the biologically overdetermined mechanism of an attachment relationship. As described earlier, a 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 and 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 et al. 2014; Fonagy and 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 toward this experience.

Recently, we have begun to view our earlier formulations of the mentalizing model of borderline personality disorder 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 and Campbell, in press). Previously, along with others (Gunderson 1996), we placed considerable weight on the role of attachment disorganization in our accounts of the disorder (Fonagy, Target, and Gergely 2000). We would like to suggest here that a broader perspective is necessary, one that places the notion of truth

experience and mentalizing in a broader biological context of social communication that guides the infant to prioritize the development of particular capacities and behaviors in order to maximize his chance of survival.

This line of thinking, grounded in Csibra and Gergely's (2006, 2009, 2011) theory of natural pedagogy (see also Hernik and Gergely 2015; Kiraly, Csibra, and Gergely 2013), takes as its starting point 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 view of human natural selection (which may arguably be applied back to the late Pleistocene age) is based on socially mediated learning and the transmission of cultural knowledge, in contrast to Darwinian evolution based on genetic transmission passed on from one generation to the next (Wilson and 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 enables 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: the learner can either work it out for himself (which is time consuming and difficult, often impossible) or trust in the communicator's authority (Sperber et al. 2010; Wilson and Sperber 2012). Trusting the communicator means that the learner does not have to go back to first principles each time he encounters novelty: e.g., 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 that communicator's assertions about the world to be regarded skeptically (Brousseau-Liard, Cassels, and Birch 2014; Durkin and Shafto 2016; Koenig and Harris 2005). What is it that enables the infant to determine who is worthy of trust, which is necessary for his vigilance to be relaxed enough to allow him to encode the social knowledge he is being offered as significant, relevant to him personally, and socially generalizable?

The key signals that allow this kind of learning to take place are the communicator's *ostensive cues* (Csibra and Gergely 2009) (an inspired suggestion based on the writing of 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 and 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 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 judgment of truth are therefore crucially dependent on the subject's having been made to feel agentive by the communicator. We can conceptualize the *moments of meeting* emphasized by the BCPSG 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, of course, is via the creation of a sense of agency (linking further to Max Weber's notions of socialization; see Giddens [1972]). The experience of truthful communication, then, to some measure at least, depends on the interpersonal context in which 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, and thus also the most consistent ostensive cueing, creating fertile ground for epistemic trust to emerge from. 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 toward the infant or child are not benign, epistemic mistrust may be a more appropriate adaptation.

Epistemic hypervigilance can manifest as the overinterpretation of motives, which can take the form of hypermentalizing (Sharp, Ha et al. 2013; Sharp, Pane et al. 2011) or pseudomentalizing (Asen and Fonagy 2012). In this state of mind, the recipient of communication assumes that the communicator's intentions are other than those declared, and are 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 the urge to treat that person 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 borderline personality disorder in adolescence (Sharp, Ha et al. 2013; Sharp, Pane 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 borderline personality disorder symptoms, which sees a reduction in impulsive symptoms over time, but no lessening of the affective and social symptoms associated with borderline personality disorder.

In a state of epistemic mistrust, the recipient of social communication may well understand what is being expressed to him, *but he cannot encode it as truthful*, as relevant to his experience, in order 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—a capacity that 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. Such persons 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, and the inbuilt natural system of epistemic vigilance becomes hyperactive. In a strange analogy to 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, and Allison 2015). 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 personality disorder (Fonagy, Luyten, and Allison 2015). 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 the patient himself* (i.e., relevant to him) and therefore potentially helpful in other social contexts. The persistent distress and social dysfunction associated with personality disorders 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 in which knowledge about oneself and one's relationships may be modified by new knowledge. It is this quality, we believe, that underlies the painful sense of isolation characterizing the subjective experience of a patient with a personality disorder.

DISCOVERING SOCIAL TRUTHS THROUGH FORGING EPISTEMIC TRUST

Notwithstanding the hard-to-reach quality of patients with personality disorder referred to above, treatments have been shown to be effective, as evidenced by randomized clinical trials (Bateman and Fonagy 1999; Clarkin, Fonagy, and Gabbard 2010; Clarkin et al. 2007; Doering et al. 2010; Gunderson and Links 2014; Jørgensen, Bøye et al. 2014; Jørgensen, Freund et al. 2013; McMain, Guimond et al. 2012; McMain, Links et al. 2009). But this is not 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) that appears to fail relative to better-structured, somewhat programmatic approaches in which treatment manuals provide 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. Pertinent 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 all effective treatments of borderline personality disorder involve the sequential implementation of three communication systems relating to the concepts of epistemic trust and social learning (Fonagy and Allison 2014). 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) to once again take place.

The initial step toward 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 and helpful to patients, and that increase the 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 the patient has things to teach the therapist. In these ways, the patient's agency is recognized, and knowledge that is felt as relevant serves as an *ostensive cue* that allows patients to move toward 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 in the therapist's 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, his theory-driven attempt to understand the patient's 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 a growing curiosity about the therapist's thoughts about him. 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 recognizes the patient as an agent, acknowledges and helps the patient identify his 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 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 trustworthy; it 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) optimizes the opportunity to regenerate epistemic trust through nonjudgmental inquisitiveness, curiosity, open-mindedness, uncertainty, not knowing, and interest in better understanding (Allen, Fonagy, and 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 cueing, which in turn generates greater access to accurate and

true social knowledge, allowing the patient to internalize new knowledge and to modify social appraisal, expectations, and behavior 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 one. Social learning in the context of epistemic trust occurs once again in the "real world." The patient's mind is opened to the truths he previously resisted via the establishment of epistemic trust (collaboration) that enables him to once again trust the social world. Thus, it is not just what is taught in therapy that teaches, but the evolutionary capacity for learning from a social situation that is rekindled. Enhanced mentalizing improves social relationships and enables one to recognize who is a reliable and trustworthy source of information and who one's *true friends* are; learning who one 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 the person comes to use his 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 patient 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 at work, according to our thinking, in the circular and self-perpetuating relationship between personality disorder 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 that 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 his social defenses—in social environments characterized by high levels of aggression or violence that prioritize an external, nonreflective, rapidly responding affective focus on others as opposed to the self.

While the epistemic mistrust of an individual with a history of trauma and personality disorder symptomatology may be an understandable defensive adaptation, the philosophical tendency to veer between a dogmatic conception of truth and an unresolvable skepticism can perhaps be seen as the manifestation 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 skeptical philosopher David Hume rapidly found that in his attempts to study causation, what he identified over and over was the role played by custom and habit in causing 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 he characterized 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, p. 172]

Hume's preferred remedy for this distress was twofold: to remind himself that, as a true skeptic, 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. [1739, p. 175]

We have seen that anxieties—on the one hand, those 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 proselytizers: that is, as working only 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 specter 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 (1921) insistence that:

In 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. [p. 69]

It is worth stressing the point that, while the theory of natural pedagogy emphasizes the vital role played by transgenerational transmission of knowledge in the development of human culture, ostensive cues are nonetheless 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, con-

tingent, marked mirroring that involves recognition of the child's subjectivity and agency is experienced as helpfully naming and organizing the child's constitutional self-states, facilitating the regulation of affect, and disposing him to learn about social cognition (Gergely and Watson 1996). Learning about ourselves in interactions 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 him make better sense of what he does 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 he is 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 ourselves known is not an end in itself, it is critical in enabling us to establish epistemic trust and build the mentalizing capacity that will allow us to successfully navigate the choppy waters of social interaction.

REFERENCES

Alexander, F. & French, T. M. (1946). *Psychoanalytic Therapy: Principles and Application.* New York: Ronald Press.
Allen, J., Fonagy, P. & Bateman, A. (2008). *Mentalizing in Clinical Practice.* Washington, DC: Amer. Psychiatric Press.
Asen, E. & Fonagy, P. (2012). Mentalization-based therapeutic interventions for families. *J. Family Ther.,* 34:347-370.

Bateman, A. & Fonagy, P. (1999). Psychotherapy for severe personality disorder—article did not do justice to available research data. *Brit. Med. J.,* 319:709-710.

——— (2010). Mentalization-based treatment for borderline personality disorder. *World Psychiatry,* 9:11-15.

Bell, D. (2009). Is truth an illusion? Psychoanalysis and postmodernism. *Int. J. Psychoanal.,* 90:331-345.

Bernardi, R. (2005). What after pluralism? Ulysses still on the road. *Psychoanal. Inquiry,* 25:654-666.

Berthelot, N., Ensink, K., Bernazzani, O., Normandin, L., Luyten, P. & Fonagy, P. (2015). Intergenerational transmission of attachment in abused and neglected mothers: the role of trauma-specific reflective functioning. *Infant Mental Health J.,* 36:200-212.

Bion, W. R. (1959). Attacks on linking. *Int. J. Psychoanal.,* 40:308-315.

——— (1962a). *Learning from Experience.* London, UK: Heinemann.

——— (1962b). A theory of thinking. *Int. J. Psychoanal.,* 43:306-310.

Blackburn, S. (2005). *Truth: A Guide for the Perplexed.* London: Penguin.

Blum, H. P. (2003). Repression, transference and reconstruction. *Int. J. Psychoanal.,* 84:497-503.

Boston Change Process Study Group (2002). Explicating the implicit: the local level and the microprocess of change in the analytic situation. *Int. J. Psychoanal.,* 83:1051-1062.

——— (2010). *Change in Psychotherapy: A Unifying Paradigm.* New York: W. W. Norton.

Breuer, J. & Freud, S. (1895). *Studies on Hysteria S. E.,* 2.

Brousseau-Liard, P., Cassels, T. & Birch, S. (2014). You seem certain but you were wrong before: developmental change in preschoolers' relative trust in accurate versus confident speakers. *PLoS One,* Sept. 25, 9(9).

Clarkin, J. F., Fonagy, P. & Gabbard, G. O., eds. (2010). *Psychodynamic Psychotherapy for Personality Disorders: A Clinical Handbook.* Washington, DC: Amer. Psychiatric Publishing.

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F. & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: a multiwave study. *Amer. J. Psychiatry,* 164:922-928.

Cooper, A. M. (2003). Commentary on "Psychoanalytic Discourse at the Turn of Our Century: A Plea for a Measure of Humility." *J. Amer. Psychoanal. Assn.,* 51(suppl.):108-114.

Csibra, G. & Gergely, G. (2006). Social learning and social cognition: the case for pedagogy. In *Processes of Change in Brain and Cognitive Development. Attention and Performance (Vol. XXI),* ed. M. H. Johnson & Y. M. Munakata. Oxford, UK: Oxford Univ. Press, pp. 249-274.

——— (2009). Natural pedagogy. *Trends Cognitive Sci.,* 13:148-153.

——— (2011). Natural pedagogy as evolutionary adaptation. *Philosophical Transactions Royal Soc. B, Biological Sci.,* 366:1149-1157.

Doering, S., Horz, S., Rentrop, M., Fischer-Kern, M., Schuster, P., Benecke, C., Buckheim, A., Martius, P. & Buckheim, P. (2010). Transference-focused psychotherapy v. treatment by community psychotherapists for borderline personality disorder: randomised controlled trial. *Brit. J. Psychiatry,* 196:389-395.

Durkin, K. & Shafto, P. (2016). Epistemic trust and education: effects of informant reliability on student learning of decimal concepts. *Child Devel.,* 87:154-164.

Eagleton, T. (1996). *The Illusions of Postmodernism.* Oxford, UK: Blackwell.

Ellman, S. J. & Moskowitz, M. (2008). A study of the Boston Change Process Study Group. *Psychoanal. Dialogues,* 18:812-837.

Ensink, K., Berthelot, N., Bernazzani, O., Normandin, L. & Fonagy, P. (2014). Another step closer to measuring the ghosts in the nursery: preliminary validation of the Trauma Reflective Functioning Scale. *Frontiers in Psychol.,* 5:1471. http://journal.frontiersin.org/article/10.3389/fpsyg.2014.01471/full.

Fonagy, P. (1998a). An attachment theory approach to treatment of the difficult patient. *Bull. Menninger Clin.,* 62:147-169.

——— (1998b). Moments of change in psychoanalytic theory: discussion of a new theory of psychic change. *Infant Mental Health J.,* 19:163-171.

——— (1999). Memory and therapeutic action (guest editorial). *Int. J. Psychoanal.,* 80:215-223.

——— (2003). Some complexities in the relationship of psychoanalytic theory to technique. *Psychoanal. Q.,* 72:13-47.

——— (2015a). The effectiveness of psychodynamic psychotherapies: an update. *World Psychiatry,* 14:137-150.

——— (2015b). Mutual regulation, mentalization and therapeutic action: a reflection on the contributions of Ed Tronick to developmental and psychotherapeutic thinking. *Psychoanal. Inquiry,* 35:355-369.

Fonagy, P. & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychother.,* 51:372-380.

Fonagy, P. & Campbell, C. (in press). Bad blood: fifteen years on. *Psychoanal. Inquiry.*

Fonagy, P., Edgcumbe, R., Moran, G. S., Kennedy, H. & Target, M. (1993). The roles of mental representations and mental processes in therapeutic action. *Psychoanal. Study Child,* 48:9-48.

Fonagy, P., Gergely, G., Jurist, E. & Target, M. (2002). *Affect Regulation, Mentalization, and the Development of the Self.* New York: Other Press.

Fonagy, P. & Luyten, P. (2009). A developmental, mentalization-based approach to the understanding and treatment of borderline personality disorder. *Devel. & Psychopathol.,* 21:1355-1381.

FONAGY, P., LUYTEN, P. & ALLISON, E. (2015). Epistemic petrification and the restoration of epistemic trust: a new conceptualization of borderline personality disorder and its psychosocial treatment. *J. Personality Disorders,* 29:575-609.

FONAGY, P., LUYTEN, P., MOULTON-PERKINS, A., LEE, Y.-W., WARREN, F., HOWARD, S. & LOWYCK, B. (in press). Development and validation of a self-report measure of mentalizing: the Reflective Functioning Questionnaire. *PloS One.*

FONAGY, P., STEELE, M., STEELE, H., HIGGITT, A. & TARGET, M. (1994). The Emanuel Miller Memorial Lecture, 1992: the theory and practice of resilience [review]. *J. Child Psychol. & Psychiatry,* 35:231-257.

FONAGY, P. & TARGET, M. (1996). Playing with reality: I. Theory of mind and the normal development of psychic reality [case reports]. *Int. J. Psychoanal.,* 77:217-233.

——— (2000). Playing with reality: III. The persistence of dual psychic reality in borderline patients. *Int. J. Psychoanal.,* 81:853-874.

——— (2005). Bridging the transmission gap: an end to an important mystery of attachment research? *Attachment & Human Devel.,* 7:333-343.

——— (2007a). Playing with reality: IV. A theory of external reality rooted in intersubjectivity. *Int. J. Psychoanal.,* 88:917-937.

——— (2007b). The rooting of the mind in the body: new links between attachment theory and psychoanalytic thought. *J. Amer. Psychoanal. Assn.,* 55:411-456.

FONAGY, P., TARGET, M. & GERGELY, G. (2000). Attachment and borderline personality disorder: a theory and some evidence. *Psychiatric Clin. No. Amer.,* 23:103-122.

FREUD, S. (1909). Analysis of a phobia in a five-year-old boy ("Little Hans"). *S. E.,* 10.

——— (1921). Group psychology and the analysis of the ego. *S. E.,* 18.

——— (1933). *New Introductory Lectures on Psycho-Analysis. S. E.,* 22.

GERGELY, G. & WATSON, J. (1996). The social biofeedback model of parental affect-mirroring. *Int. J. Psychoanal.,* 77:1181-1212.

GIDDENS, A. (1972). *Politics and Sociology in the Thought of Max Weber.* London: Macmillan, 2013.

GRÜNBAUM, A. (1984). *The Foundations of Psychoanalysis: A Philosophical Critique.* Berkeley, CA: Univ. of California Press.

——— (2008). Popper's fundamental misdiagnosis of the scientific defects of Freudian psychoanalysis and of their bearing on the theory of demarcation. *Psychoanal. Psychol.,* 25:574-589.

GUNDERSON, J. G. (1996). The borderline patient's intolerance of aloneness: insecure attachments and therapist availability. *Amer. J. Psychiatry,* 153:752-758.

GUNDERSON, J. G. & LINKS, P. L. (2014). *Handbook of Good Psychiatric Management (GPM) for Borderline Patients.* Washington, DC: Amer. Psychiatric Press.

HARTMANN, H. (1955). Notes on the theory of sublimation. *Psychoanal. Study Child,* 10:9-29.

Hattie, J. (2013). *Visible Learning: A Synthesis of Over 800 Meta-Analyses Relating to Achievement.* London: Routledge.

Hernik, M. & Gergely, G. (2015). To what adaptive problems is human teaching a solution? *Behavioral Brain Sci.,* 38:26-27.

Hume, D. (1739). *A Treatise of Human Nature.* Oxford, UK: Oxford Univ. Press, 2000.

Jimenez, J. P. (2008). Theoretical plurality and pluralism in psychoanalytic practice. *Int. J. Psychoanal.,* 89:579-599.

Jørgensen, C. R., Bøye, R., Andersen, D., Døssing Blaabjerg, A. H., Freund, C., Jordet, H. & Kjølbye, M. (2014). Eighteen months post-treatment naturalistic follow-up study of mentalization-based therapy and supportive group treatment of borderline personality disorder: clinical outcomes and functioning. *Nordic Psychol.,* 66:254-273.

Jørgensen, C. R., Freund, C., Bøye, R., Jordet, H., Andersen, D. & Kjølbye, M. (2013). Outcome of mentalization-based and supportive psychotherapy in patients with borderline personality disorder: a randomized trial. *Acta Psychiatrica Scandinavica,* 127:305-317.

Kernberg, O. F., Yeomans, F. E., Clarkin, J. F. & Levy, K. N. (2008). Transference focused psychotherapy: overview and update. *Int. J. Psychoanal.,* 89:601-620.

Kiraly, I., Csibra, G. & Gergely, G. (2013). Beyond rational imitation: learning arbitrary means actions from communicative demonstrations. *J. Experimental Child Psychol.,* 116:471-486.

Koenig, M. A. & Harris, P. L. (2005). The role of social cognition in early trust. *Trends in Cognitive Sci.,* 9:457-459.

McMain, S. F., Guimond, T., Streiner, D. L., Cardish, R. J. & Links, P. S. (2012). Dialectical behavior therapy compared with general psychiatric management for borderline personality disorder: clinical outcomes and functioning over a two-year follow-up. *Amer. J. Psychiatry,* 169:650-661.

McMain, S. F., Links, P. S., Gnam, W. H., Guimond, T., Cardish, R. J., Korman, L. & Streiner, D. L. (2009). A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. *Amer. J. Psychiatry,* 166:1365-1374.

O'Shaughnessy, E. (1994). What is a clinical fact? *Int. J. Psychoanal.,* 75:939-947.

Recanati, F. (1997). Can we believe what we do not understand? *Mind & Language,* 12(1), 84-100.

Renik, O. (1998). The analyst's subjectivity and the analyst's objectivity. *Int. J. Psychoanal.,* 79:487-497.

——— (2005). Standards and standardization. *Fort Da,* 11:60-72.

Russell, B. (1940). *An Inquiry into Meaning and Truth.* London: Allen & Unwin.

Ryle, A. (2003). Something more than the "something more than interpretation" is needed: a comment on the paper by the Process of Change Study Group. *Int. J. Psychoanal.,* 84:109-118.

SHARP, C. & FONAGY, P. (2008). The parent's capacity to treat the child as a psychological agent: constructs, measures and implications for developmental psychopathology. *Social Devel.,* 17:737-754.

SHARP, C., HA, C., CARBONE, C., KIM, S., PERRY, K., WILLIAMS, L. & FONAGY, P. (2013). Hypermentalizing in adolescent inpatients: treatment effects and association with borderline traits. *J. Personality Disorders,* 27:3-18.

SHARP, C., PANE, H., HA, C., VENTA, A., PATEL, A. B., STUREK, J. & FONAGY, P. (2011). Theory of mind and emotion regulation difficulties in adolescents with borderline traits. *J. Amer. Acad. Child & Adolescent Psychiatry,* 50:563-573.

SPERBER, D., CLEMENT, F., HEINTZ, C., MASCARO, O., MERCIER, H., ORIGGI, G. & WILSON, D. (2010). Epistemic vigilance. *Mind & Language,* 25:359-393.

TARGET, M. & FONAGY, P. (1996). Playing with reality: II. The development of psychic reality from a theoretical perspective. *Int. J. Psychoanal.,* 77:459-479.

TRONICK, E. Z. (2007). *The Neurobehavioral and Social-Emotional Development of Infants and Children.* New York: W. W. Norton & Company.

TUCKETT, D. (2005). Does anything go? Towards a framework for the more transparent assessment of psychoanalytic competence. *Int. J. Psychoanal.,* 86:31-49.

WALLERSTEIN, R., ed. (1992). *The Common Ground of Psychoanalysis.* Northvale, NJ: Jason Aronson.

WILSON, D. & SPERBER, D. (2012). *Meaning and Relevance.* Cambridge, UK: Cambridge Univ. Press.

WILSON, D. S. (1976). Evolution on the level of communities. *Science,* 192:1358-1360.

——— (2013). Human cultures are primarily adaptive at the group level. *Cliodynamics: J. Theoretical & Mathematical History,* 4:102-138.

WILSON, D. S. & WILSON, E. O. (2007). Rethinking the theoretical foundation of sociobiology. *Q. Rev. Biol.,* 82:327-348.

WOLF, E. S. (1992). On being a scientist or a healer. *Ann. Psychoanal.,* 20:115-129.

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