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RESEARCH ARTICLE

A theory-building case study of resolving epistemic mistrust and developing epistemic trust in psychotherapy with depressed adolescents*

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ABSTRACT

Objective: Patients with epistemic mistrust struggle to view others as trustworthy sources of knowledge and often default to negative appraisals in social communication. The three communication systems theory posits that resolving epistemic mistrust involves three systems: the epistemic match, improving mentalizing, and the re-emergence of social learning outside therapy. This study aimed to empirically examine the theory to understand how epistemic trust develops in psychotherapy.
Method: Using a theory-building case study approach, we analyzed therapeutic processes in six depressed adolescents (*M*age = 16.58, SD = 1.17) with varying treatment outcomes. Sixty-six audiotaped psychotherapy sessions were reviewed to compare good- and poor-outcome cases, identifying patterns within therapeutic interactions.
Results: Findings provide the first empirical evaluation of the three communication systems theory, offering concrete examples of how it unfolds in clinical practice and suggesting refinements in therapist and patient processes to build epistemic trust. Additional insights into the theory highlight an early "window of opportunity" to foster epistemic openness, the influence of environmental factors outside therapy, and the interactive nature of therapist-patient dynamics.
Conclusion: This study refines the theoretical understanding of epistemic trust in psychotherapy, revealing specific therapist and patient behaviors that may facilitate its development. Implications for clinical practice and future research directions are discussed.

Keywords: psychotherapy process; epistemic openness; adolescent depression; therapeutic relationship; therapist responsiveness

Clinical or methodological significance of this article: This study provides preliminary evidence supporting Fonagy et al.'s (2019) notion that how therapists communicate with their patients impacts the development of *epistemic trust*—patients' openness to interpersonally shared knowledge through social communication. The findings emphasize the importance of starting therapy by making the therapy feel personally relevant and attuned to the patient's model of their own mind, and creating shared understanding to encourage openness to new perspectives. *How* therapy is delivered, rather than the specific type of therapy, may be crucial for working with patients entering treatment with high mistrust and limited support. Therapists may benefit from learning techniques that help establish an *epistemic match* to enhance patients' openness to communication, regardless of the therapeutic approach.

*This study was not preregistered. Study materials are not publicly available. A small portion of the data and analysis from this study have appeared in the presentations for the 28th Annual British Association for Counselling and Psychotherapy (BACP) Research Conference and the Society for Psychotherapy (SPR) 54th International Annual Meeting. Data have been reanalyzed and integrated for the present article.
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A theory-building case study is an approach in which single cases are analyzed in depth to generate or refine theories, integrating empirical observations within existing frameworks (Stiles, 2007). In this theory-building case study, we tested propositions from Fonagy et al.'s *three communication systems* theory (2015, 2017, 2019), which suggests that the systems—achieving an epistemic match, enhancing mentalizing, and fostering the re-emergence of social learning beyond therapy—are implicative in effective psychotherapy. Although the theory has been delineated to explain how epistemic mistrust is resolved and epistemic trust restored, it remains unexamined in clinical contexts. This study addresses this gap by empirically analyzing clinical observations across multiple cases, allowing us to explore whether specific therapeutic interactions support or contradict the theory's assumptions. By incorporating these observations into the three communication systems, we aim to illustrate key concepts and adapt it to better capture the nuances of therapeutic processes in real-world settings.

Epistemic trust refers to the capacity to acquire and accommodate new information in a way that supports resilient social functioning (Fonagy et al., 2015). Infants develop an openness to receiving social communications from their primary caregivers within the context of early attachment relationships, as an adaptation that enables them to survive and benefit from their environment (Fonagy et al., 2015). However, children and young people exposed to abuse and deprivation early in life may learn to survive by remaining hypervigilant toward others. Baylin and Hughes (2016) theorized this as blocked trust, a chronically hypervigilant state of mind that takes precedence over the development of brain circuitry that supports social engagement. Fonagy et al. (2015) described this state as *epistemic mistrust*, which is thought to capture an underlying propensity for various forms of psychopathology. Individuals with a stance of epistemic mistrust are less likely to trust others as a source of knowledge about the world and tend to adopt negative appraisal mechanisms as a default in social communication (Fonagy et al., 2017). Mistrust of this nature closes off the acceptance of new information, thereby impeding meaningful change and adaptation to evolving conditions.

Within clinical settings, the role of trust has long been recognized as central in establishing effective therapeutic relationships. Individuals are more likely to modify their behaviors based on relationships with trusted others (Wampold, 2012). Psychotherapy represents a unique form of social communication and learning from others. Given that trust is a key element in successful interpersonal interactions, it has been described as a marker for change in psychotherapy (Salgado, 2014). Psychotherapy research highlights how an alliance between therapist and patient, emerging from a general sense of trust, contributes to therapeutic change (e.g., Crits-Christoph et al., 2019; Farber & Metzger, 2009; Noyce & Simpson, 2018; Trasmundi & Philipsen, 2020). In a review, Mohr (1995) found that individuals who respond negatively to psychotherapy often report difficulties in trusting others and greater uncertainty about their therapists' feelings.

This may be particularly relevant for young people, as research suggests that many adolescents may not inherently trust their therapist (e.g., Hardin et al., 2021). Depression is one of the most prevalent mental health issues in adolescence, with substantial evidence suggesting that, if left untreated or unresolved, it can lead to significant negative outcomes (Bor et al., 2014; Clayborne et al., 2019; Fink et al., 2015; Polanczyk et al., 2015). Moreover, evidence suggests that young people commonly report lower rates of improvement following routine clinical care for depression compared to adult patients, thus signifying the need to further explore factors that may moderate positive treatment outcomes for this population (Bear et al., 2020). Given these challenges, the current study examined a series of psychotherapy cases with depressed adolescents to test and refine the three communication systems theory, specifically by investigating how epistemic mistrust may be resolved and epistemic trust develop in psychotherapy.

Fonagy and colleagues (Bateman et al., 2018; Fonagy et al., 2017, 2019; Fonagy & Campbell, 2015; Luyten et al., 2020) proposed a framework of *three communication systems* associated with effective psychotherapeutic interventions (see Figure S1). The first communication system involves conveying the therapeutic model in a way that is specifically applied and adapted to the patient's unique experience, thus communicating to the patient the therapist's recognition of their subjective agency. By providing a model for understanding the patient's mind, alongside a caring intent in a calm, boundaried environment, the possibility for patient learning is opened up. In the second communication system, the therapist actively supports the patient's *mentalizing*, that is their capacity to reflect on the mental states (i.e. thoughts and feelings) that drive their own and other peoples' behaviors. As the patient's ability to mentalize strengthens, they internalize their therapist's insights, often leading to shifts in how they perceive themselves and others. In the third communication system, social learning re-emerges and extends beyond the therapeutic relationship, enabling the patient to actively benefit from their social environment. This process allows the patient to proactively seek social connections,

build or prepare for new relationships, and redefine existing ones, applying skills and insights gained in therapy to navigate and strengthen their broader social world. These three systems function in a sequential yet iterative manner: each system builds on the previous one, with System 1 enabling System 2, and System 2 facilitating System 3. However, earlier systems are revisited and reiterated throughout the process, rather than being completed in a strict, linear progression.

Objective

Although the theoretical model for establishing epistemic trust in psychotherapy has already been outlined, and the concept of epistemic trust has begun to inform research in psychotherapy and relationship-building (e.g., Jaffrani et al., 2020; Li et al., 2022; Sprecher et al., 2022; Thomas & Jenkins, 2019), no study has yet empirically examined the specific process by which epistemic mistrust may be resolved in psychotherapy (Li et al., 2023). This study aims to address this gap by utilizing a theory-building case study approach (Stiles, 2007, 2009) to explore how epistemic mistrust is resolved and how epistemic trust is established in brief psychotherapy for adolescent depression. We used previously collected data from a large-scale randomized clinical trial, the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT) study (Goodyer et al., 2017) and analyzed 66 audiotaped sessions from six adolescents who entered treatment with explicit signs of epistemic mistrust. Although many theory-building case studies focus on a single case to provide in-depth analysis, the present study uses six cases to allow for a comparative examination of successful and unsuccessful outcomes, capture variations in therapeutic processes, and strengthen the empirical foundation of the three communication systems theory by identifying patterns related to resolving epistemic mistrust across different individuals. This theory-building approach enables us to empirically evaluate the theory by identifying which aspects align with or challenge its assumptions. Our research question and analysis focus on how epistemic mistrust is resolved and epistemic trust is established in psychotherapy, aiming to refine the theory into a model that captures this transformative process.

Method

Case Selection

This study used data from the IMPACT study (Goodyer et al., 2017), a pragmatic effectiveness trial that randomized 465 clinically depressed adolescents across 18 child and adolescent mental health services in England to one of three treatments: cognitive–behavioral therapy (CBT), short-term psychoanalytic psychotherapy (STPP), and brief psychosocial intervention (BPI). Adolescents were randomly and blindly assigned evenly across the three therapies. Each therapy type adhered to a manualized protocol: CBT offered up to 20 sessions over 30 weeks, STPP up to 28 sessions over 30 weeks, and BPI up to 12 sessions over 20 weeks; although in practice, they attended a median of 6–11 sessions (for more details, please see Goodyer et al., 2017). Outcome assessments were conducted at baseline, end of treatment (36 weeks), and 1-year follow-up (86 weeks) using the Mood and Feelings Questionnaire (MFQ; Angold et al., 1995) to measure depression severity.

We used purposive sampling to select cases rich in the phenomenon of interest, as recommended for theory-building case studies (Stiles, 2007). A previous study (Li et al., 2022) identified 15 cases of depressed adolescents showing explicit signs of epistemic mistrust based on their baseline interview data. Explicit indicators of epistemic mistrust included a reported tendency to perceive social interactions and communication as irrelevant, non-beneficial, or even harmful sources of information. This was often accompanied by coping strategies like self-isolation and avoidance of social activities, limited capacity to reflect on their own and others' mental states, and negative expectations of others as untrustworthy or incapable of offering meaningful support. Examples and further details can be found in Li et al. (2022).

From the initial 15 cases (Li et al., 2022), we selected six cases for the current study based on two criteria. First, we included only cases with audiotapes of all therapy sessions available to allow for a fine-grained exploration of psychotherapy processes. Second, we selected contrasting cases to highlight varied therapeutic trajectories: successful cases, defined as those showing a shift from the clinical range (MFQ scores of 27 or above) to the nonclinical range with at least a 50% reduction in depressive symptoms by the end of treatment, and unsuccessful cases, where MFQ scores of 27 or higher persisted at both the end of treatment and the 1-year follow-up. Cases were excluded if treatment had not started ($n = 2$), ended within five sessions ($n = 4$), had incomplete audio recordings ($n = 1$), or did not meet criteria for good or poor outcomes ($n = 2$), resulting in a final sample of six cases for analysis (see Table S1 in Supplemental Material for details). The six cases (five females; *M*age = 16.58, SD = 1.17; 66 audiotaped sessions) included four with good treatment outcomes and two with poor outcomes (see Table S2 for details; identities are

anonymized). Based on prior findings (Li et al., 2022), the four adolescents with good outcomes reported a shift from epistemic mistrust to epistemic trust, largely attributed to therapy. The two with poor outcomes remained mistrustful and pessimistic about social communication through treatment and 1-year follow-up. This sample is not intended to be representative of the overall program.

Ethical approval was granted by the the Cambridge 2 Research Ethics Committee (REC Ref: 09/H0308/137). Informed written consent was obtained from participants at baseline, with additional parental consent for those under 16. The policies from University College London, Anna Freud National Centre for Children and Families, and local National Health Service (NHS) Trust on data protection procedures and confidentiality were followed. Pseudonyms were used, and identifiable information was modified to ensure confidentiality.

Theory-Building Case Study Approach

Theory-building case studies, as described by Stiles (2007, 2009), involve iterative processes of deduction, induction, and abduction to refine and adapt theories through clinical observations across cases. Following Stiles' model, we used this approach to assess how clinical observations from the six cases (four successful and two unsuccessful) aligned with or challenged elements of the three communication systems theory. A total of 66 audiotaped therapy sessions were analyzed. Key interactions relevant to resolving epistemic mistrust were first mapped against theoretical constructs using deductive reasoning. Inductive analysis then identified emergent patterns and deviations, capturing unique trajectories across cases. Abductive reasoning finally synthesized these findings, refining the theoretical framework to better accommodate observed phenomena.

The analysis began with deductive reasoning, which tested predefined theoretical constructs against the observed data. Key constructs from the three communication systems theory, such as epistemic openness, mentalizing, and re-emerged social learning were used as benchmarks. Patient behaviors indicative of epistemic mistrust (e.g., avoidance of social interaction, negative interpretations of others' intentions) and epistemic trust (e.g., openness to alternative explanations, proactive pursuit of helpful knowledge) were systematically identified and compared with theoretical predictions. Therapist strategies relevant to facilitating epistemic trust, such as marked mirroring, were evaluated to assess their role in fostering epistemic openness and supporting alignment with the theory.

Next, inductive reasoning was applied to uncover emergent patterns and deviations from the theoretical constructs, allowing insights to surface organically without being constrained by predefined theoretical constructs. This process involved open coding of the therapy session transcripts, where recurring phrases, behaviors, and interactions were identified (e.g., *therapist validation*, and *patient resistance*). These initial codes were then grouped into broader categories that captured higher-level patterns, such as grouping *the therapist's use of validation techniques* to *establish epistemic openness*. Patterns within and across cases were later compared to identify commonalities and distinctions. For example, successful cases often progress from *therapist validation* to *patient openness*, while unsuccessful cases appeared stalled or lacked such progression. Emerging patterns were continually re-evaluated in light of new data to ensure that identified themes accurately represented the session dynamics. For example, early codes like *patient resistance* were refined to distinguish between *hesitant engagement* and *active avoidance*. Overarching themes, such as *creating epistemic openness through marked mirroring*, formed the basis for theoretical insights that synthesized deductive, inductive, and abductive findings.

Finally, abductive reasoning synthesized findings from both deductive and inductive analyses, refining the theoretical framework to better explain observed phenomena. Discrepancies between the original theory and the data were used to adapt and extend the model. For example, an unsuccessful case demonstrated how the absence of an early epistemic match during the critical initial phase might reinforce the patient's negative perceptions of the therapist's reliability, leading the patient to view subsequent communication from the therapist as irrelevant, unhelpful, or even harmful. This abductive reasoning suggested that establishing an epistemic match early in treatment may be crucial to signaling the therapist as a trusted source of relevant insight, fostering the patient's willingness to engage with and consider what is being communicated.

The first author conducted the primary analysis, with regular team meetings to review relevant excerpts, discuss interpretations, and resolve discrepancies. Raw data were revisited iteratively to refine the coding framework. Trustworthiness was ensured through triangulation across cases, prolonged engagement with the data, and maintaining an audit trail of analytic decisions. These efforts were complemented by reflexive discussions within the research team, who acted as critical reviewers to ensure that interpretations remained closely aligned with the observed data and adhered to the intended methodology. This collaborative process mitigated interpretative biases and enhanced reliability and validity by integrating multiple

perspectives. For example, the team deliberated on whether a patient's silence reflected resistance or reflective processing, analyzing the context, interaction within that segment, the session as a whole, and the overall trajectory of therapy.

Researcher Reflexivity

Our research team consists of therapists and researchers with extensive expertise in psychoanalytic and psychodynamic approaches. The team includes an early-career researcher specializing in developmental psychopathology and psychotherapy research, who is also an early-career therapist with an integrative approach, primarily rooted in psychodynamic principles while incorporating broader therapeutic frameworks; a highly experienced child and adolescent psychotherapist with extensive research experience in child psychotherapy; a mid-career researcher specializing in psychoanalytic and psychodynamic psychology; and a highly experienced psychoanalytic and psychodynamic psychotherapist with extensive clinical and research experience in psychoanalysis and psychotherapy.

Members of the team are actively engaged in both psychotherapy research and practice, enabling an integration of theoretical and empirical perspectives. Given the varying levels of experience among the authors, we engaged in ongoing reflexive discussions throughout the research process, critically examining assumptions and interpretations. We ensured that our analysis remained closely grounded in the data by consistently returning to the exact words of the patient and therapist, along with their context, to prevent interpretations from being overly shaped by theoretical assumptions or broad generalizations. The study spanned three years of analysis and write-up, allowing us to engage in continuous reflection rather than relying on simplistic interpretations. This extended timeframe enabled us to critically reassess our assumptions, refine our interpretations, and remain attuned to the nuances of the therapeutic process. To further enhance rigor and trustworthiness, we conducted multiple rounds of peer review within the research team and sought feedback from highly experienced researchers in the field, who are recognized in the Acknowledgements section.

Results

Case Characteristics and Theoretical Starting Points

The six selected cases began therapy with prominent signs of epistemic mistrust, characterized by self-imposed isolation, strained relationships, limited social support, and a pervasive mistrust of their social environment (see Table S3). The theoretical starting point for each case focused on the progression from epistemic mistrust to epistemic trust, facilitated by the three communication systems (Fonagy et al., 2015, 2017, 2019). At the end of treatment, four cases with good treatment outcomes all displayed signs of epistemic trust and a re-emergence of social engagement, demonstrated by redefined and repaired existing relationships, the formation of new interpersonal connections, and proactive engagement in social activities; while two cases with poor treatment outcomes showed sustained mistrust and minimal social reintegration and neither acknowledged receiving support within or beyond therapy by the end of treatment (see Table S4).

Key Process and Observations in Cases

We will present typical examples and excerpts to illustrate key findings, representing broader trends observed throughout the dataset. While only a subset of interactions is presented, each case was analyzed comprehensively, and the results and conclusions reflect patterns derived from a thorough, iterative analysis of all available psychotherapy session data. It is worth noting that these examples are not intended as definitive evidence of causality but rather as exploratory observations that align with the theory-building approach of this study.

Communication system 1: Epistemic match and openness. As depicted in Figure S2, the first phase of therapy focused on establishing the patient's epistemic openness by first creating an *epistemic match* between the patient and therapist. This epistemic match was fostered through two key therapist processes: (1) marked mirroring – where the therapist reflects the patient's emotions or felt experiences in a way that signals shared understanding while subtly indicating that it is the therapist's empathic response and genuine attunement to the patient's experience; and (2) applying the therapeutic model to show treatment relevance – where the therapist contextualizes the patient's difficulties within the treatment framework, which can be seen as ostensive cues to signal why the therapy is relevant and useful to the patient's specific concerns. Ostensive cues are signals that indicate the relevance, importance, or trustworthiness of communicated information. In the context of therapy, ostensive cues may help patients recognize how the therapeutic model applies to their own experiences and how therapy

can address their specific struggles, which in turn may help create an epistemic match. Together, marked mirroring and applying the therapeutic model to the patient's specific concerns may help establish epistemic match between the patient and therapist, which in turn may facilitate epistemic openness—the patient's readiness to accept and engage with new perspectives of their own experiences a therapist they perceive as attuned and capable of helping.

Marked mirroring was evident in all good-outcome cases, where therapists validated the patients' subjective experiences, fostering a shared understanding that facilitated epistemic openness. For example, Lydia's CBT therapist empathically validated her experience of social isolation by reflecting her feelings: *"That sounds like a really painful time […] It sounds like the only place you can go is in your head."* Following this response, Lydia moved beyond brief acknowledgment and elaborated on her experiences, saying: *"Yeah, as I can remember I have never gone out of the house […] So I guess that's why […]"*. This moment established an epistemic match, as the therapist's marked mirroring aligned with Lydia's subjective experience, creating a shared understanding. As the conversation continued, Lydia began to explore her thoughts, adding: *"I don't know, it's like, when I think about it, I feel like I've just been stuck […] like I want to do something about it, but I don't know how […] Is this normal?"*. This shift from minimal self-disclosure to increasing reflection suggests a moment of epistemic openness, where she was engaging more deeply in the therapeutic conversation and provided additional personal details. This interaction suggests that marked mirroring from the therapist may facilitate epistemic openness in the patient by creating a shared understanding that encourages the patient's readiness to explore new perspectives within therapy.

Similarly, Alice, who initially struggled with verbal expression and often responded with short, surface-level phrases (*"I don't know", "I'm okay,"* or simply remained quiet), began speaking more after her therapist provided marked mirroring and interpretations that resonated with her internal conflicts. Alice's STPP therapist noted her difficulty in expressing herself by remarking, *"Even if you're looking fine and sounding fine, it doesn't mean that you are necessarily fine inside."* This communication demonstrated the therapist's recognition of Alice's emotional state, aligning with the theory's focus on fostering an epistemic match by accurately reflecting the patient's inner experience. Likewise, noticing Alice's habitual lateness, the therapist explored her underlying motivations, saying,

> I wonder if there is something about Alice who wants to stay longer in her sleep world or in your room to yourself, not having to be out there in the world and trying to put that off. Perhaps especially when things can go wrong, it can be quite hard to face.

Alice, who had initially been hesitant to acknowledge her struggles, paused before responding, then tentatively engaged with this reflection, saying: *"I mean … yeah, I guess. It's like, when I wake up, I just don't feel ready to deal with everything. Like, I know I should get up, but I just … don't."* By acknowledging these underlying motivations, the therapist provided marked mirroring that resonated with Alice's unspoken, or even unconscious, feelings and experiences. Alice's response suggests that the therapist's marked mirroring helped her begin to articulate and explore an internal conflict she had previously struggled to put into words, offering an opportunity to build a deeper epistemic connection.

In addition to marked mirroring, therapists in all good-outcome cases applied their therapeutic model to their patients' specific problems, thus implicitly communicating the treatment relevance. For example, Lydia's CBT therapist introduced the concept of a "vicious cycle" in negative thinking, explaining,

> What you think and feel can cause a vicious cycle […]. Is that actually your thoughts that "I'm actually not that good", yeah? In comparison with other people so feel like "I'm the lowest", yeah? At the moment you maybe feel a bit anxious, a bit low, yeah? […] Lots of negative thoughts stuck in your head at the time […]

This explanation contextualized Lydia's experience within the CBT framework, potentially signaling the treatment's relevance to her struggles. Following this response, Lydia actively engaged with the theoretical concept, saying:

> Is this what you do to everything?" "Yeah, I always feel I'm doing nothing. I just feel like wasting time […] Because when I think I'm failing, I just stop trying, and then I feel even worse about myself." "If I have a goal, how do I make efforts?

This transition—from passive listening to active inquiry—suggests that Lydia began exploring how the concept of a vicious cycle applied to her experiences, demonstrating increasing epistemic openness through her engagement.

Following a different therapeutic approach, Alice's STPP therapist conveyed an openness to all forms of Alice's psychic experience, trying to stay attuned to potential unconscious motivations shaping Alice's behaviors and relationships. In addition to the

example provided above, the STPP therapist, in accordance with a psychoanalytic treatment model, tried to help Alice recognize and articulate her inner conflicts. For example, the therapist attempted to reflect on her patient's inner struggles by saying: *"It feels like you have two sides of yourself working against each other."* Initially, Alice responded tentatively, but over time, she internalized and verbalized her therapists' understanding in her own words: *"I'm so against myself, like two sides always, like I don't know, like they don't work together, they're like opposed or something […]"* By framing Alice's internal struggles within the therapeutic model, the therapist provided an ostensive cue, demonstrating how new knowledge from therapy could be directly applicable to her lived experience. This alignment between the therapist's insights and Alice's personal experiences may have fostered an epistemic match, which in turn encouraged greater receptivity to new perspectives. As a result, Alice gradually integrated the therapist's insights into her own way of thinking and verbalized her experiences, shifting from initial hesitation and guardedness to a more open and engaged stance in therapy.

This pattern—where the therapist's marked mirroring and the use of ostensive cues to highlight the relevance of therapy to facilitate epistemic match—was similarly observed in Cora and Rachel's cases. In Cora's case, the BPI therapist appeared to foster an epistemic match by using marked mirroring as well as aligning practical guidance and psychoeducation with Cora's specific concerns. For example, when Cora discussed her depression and family issues, the therapist validated her feelings by normalizing her experience and framing it as something shared by others, saying,

> A lot of kids suffer with these moods and feel this way when their parents split up […] Do you have an idea in your mind why they split up?" "Because sometimes some children would think they contributed to it, it's their fault. Do you ever feel that way?

By framing Cora's feelings as common emotional responses to parental separation, the therapist tried to mirror Cora's feelings while also acknowledging her distress. This may have helped reduce her sense of isolation and created opportunities for a shared understanding, positioning the therapist as a trustworthy source of guidance. At first, Cora hesitated, but after a pause, she responded with tentative self-reflection, saying: *"I don't know … I mean, I never really thought about it, but maybe? Like, sometimes I do feel like … if I had been better or something, maybe things would be different."* This interaction suggests how the therapist's marked mirroring and psychoeducation provided an epistemic match that allowed Cora to reconsider and articulate her emotions in a way she had not done before, reflecting a shift toward epistemic openness in the therapeutic relationship.

Similarly, the BPI therapist helped Cora make sense of her interpersonal challenges through psychoeducation and guidance. In the early sessions, Cora was defensive and hesitant to accept alternative explanations regarding her social relationships. The therapist reflected back a possible social dynamic, saying:

> It sounds like there's a lot of tension between you two. Could it be that she sees something in you—your grades, how you get along with others—that makes her feel left out?
>
> Sometimes in friendships, one person might feel left out when they see another person doing well in school or getting along with others. Have you ever noticed anything like that?

Initially, Cora resisted the idea, but as the conversation continued, she stated: *"I mean, I do have people talking to me, and it's not like I'm on my own. When there's no argument, I've got people around me. And, as you said, I'm quite good in school. I get good grades. Maybe she noticed that."* By linking Cora's personal experiences with a broader psychoeducational framework, the therapist may have helped her process relational experiences in a more structured way, implicitly conveying the personal relevance of the therapeutic model to Cora.

The possible impact of these therapist communications became evident in patients' subsequent engagement with therapy. In Rachel's case, for example, therapist validation seemed to support her view of therapy as a space for self-expression. Initially, Rachel was highly skeptical and resistant to trusting others, frequently describing herself as isolated and misunderstood. However, as the therapist provided explicit understanding that aligned with Rachel's personal experiences, Rachel began seeking further clarification and engaged more actively in the learning process, she noted, *"I never really expressed this before ever. It just came up today […] I just never really talked about it […]"*. This moment indicated her tentative transition from epistemic mistrust to openness, suggesting that the therapist's alignment may have played a role in fostering her willingness to share her thoughts more freely.

In contrast, the poor-outcome cases did not achieve the same level of epistemic match in early sessions, which may have contributed to their limited progress. Nathan's therapist, for example, provided minimal feedback in initial sessions, often responding with extended periods of silence after

Nathan shared personal details. These silences may have left Nathan uncertain about how his feelings were being received. When the therapist did speak, it was with brief, surface-level comments like "*Oh yeah?*" "*You think?*" "*Yeah?*" "*Oh really?*" and "*What else?*". Although brief comments like "*What else?*" can sometimes facilitate exploration, in this context, they often followed long silences from the therapist and were the only type of responses provided by the therapist throughout the session. Without additional engagement or meaningful interaction, the combination of prolonged silences followed by such brief, comments might have made Nathan feel that his emotional experiences were not understood, acknowledged, or valued, deepening his sense of isolation. Additionally, this type of communication may have failed to convey the relevance of the therapy, or signal the therapist as a trusted source of helpful insight. Indeed, it was observed that Nathan remained guarded, expressed confusion about the therapist's purpose, and ultimately disengaged from the therapeutic process.

Communication system 2: Increased mentalizing. As the patient began to feel understood and perceive the therapist as a potentially trustworthy source of new knowledge, their increasing epistemic openness appeared to allow them to move into System 2. Here, the therapist moved beyond implicit validation and began explicitly modeling a reflective stance, encouraging the patient to engage in more complex and deliberate thinking about their own mind and the minds of others. A marker of this phase may involve patients not only receiving mentalizing from the therapist but also starting to adopt and apply it themselves. This may include inquiring about the complex inner states that may underlie their actions and becoming more curious about their own mind. By engaging in this interactive process of perspective-taking and reflection, patients may begin tentatively testing new perspectives, verbalizing previously unarticulated conflicts, and expressing uncertainty in a more reflective and exploratory manner. Through this shift, the patient may have moved from passively receiving understanding (System 1) to actively participating in the mentalizing process (System 2), fostering more flexible and adaptive ways of thinking and relating to others. Whereas System 1 was primarily about the therapist creating an epistemic match through marked mirroring and making therapy feel personally relevant—laying the groundwork for openness to new perspectives—System 2 may have facilitated the patient's own capacity for mentalization by engaging them in reflective processes.

In Cora's case, the therapist's consistent support with mentalization on the self and others offered perspectives that might not have been readily accessible to Cora. By helping her examine her family dynamics and feelings toward her parents, the therapist offered insights that went beyond Cora's initial beliefs, stating, *"You feel a bit rejected [...] You are disappointed that he can't prioritize you [...]"* This interaction seemed to encourage Cora to reassess her earlier views, leading her to a more nuanced understanding of her relationships with her parents: *"When I was younger, I blamed my mom [...] Now I understand why [...]"* The therapist's mentalizing stance seemed instrumental in helping Cora develop a new understanding of herself and her parents and reframe her experiences in a way she had not previously considered.

In later sessions, Cora's experience further illustrated how therapists might serve as a model for patients by exemplifying certain attitudes and behaviors that patients can observe and learn from. Through modeling a reflective stance, therapists can offer examples of how to explore and approach inner experiences with openness and curiosity, encouraging patients to adopt a similar approach toward self-understanding and relationships. For instance, during a session where Cora expressed feeling overwhelmed by her emotions, the therapist acknowledged her distress while introducing a more regulated perspective, saying:

> I can hear how overwhelming this feels for you, like it's spiraling out of control. But I wonder if there's a way to step back and remind yourself... in fact, you need to tell yourself, "Cora, this anxiety is manageable, it's something I can work with, something that doesn't have to control me completely."

By verbalizing an alternative way of relating to emotions, the therapist modeled an attitude of self-reflection and self-regulation, reinforcing the idea that difficult emotions can be acknowledged without being overwhelming. Interactions like this appeared to provide Cora with a framework for viewing her emotions with greater control and agency, helping her develop a more reflective and adaptive response to distress. This process might have contributed to strengthening Cora's mentalizing skills and sense of self. Reflecting on a specific encounter, she expressed newfound assertiveness, saying:

> It's like having a psychological effect on people—not afraid to say what it is now. As I said before, not to get myself into trouble. There's a very vicious girl swearing at me [...] I was proud of myself for not being afraid of saying what I'm saying now. I told

> myself, whatever she said, she can't hurt me. It's just like it's my choice. That is my decision.

This example illustrates how the therapist's attuned modeling of self-reflection and agency might support patients in reshaping their personal narratives and developing a stronger sense of self.

Moreover, Communication System 2 also appeared to involve the patient and therapist beginning to see each other as intentional agents with the capacity to influence one another's mental processes. For instance, Rachel shared, *"But I'm the kind of person that's like, I don't want to disappoint you and that's enough of an incentive for me to do something."* In response, the therapist acknowledged this tendency:

> It makes me think that maybe I need to be more aware that you might be doing things […] because you want to be compliant rather than because it makes sense for you. So how could you let me know when you don't want to do something?

For Rachel, this interaction seemed to create an opportunity to reflect, as she shared, *"I have faith that you're asking me to do the right thing. It's not like you're telling me to, like, you know, damage myself or anything. I know it's going to help me and stuff […]"* This exchange illustrates how the therapist's validation of Rachel's concerns and her collaborative reflection likely helped Rachel see the therapeutic relationship as a safe and reciprocal space, where both patient and therapist could engage as active participants with the potential to shape each other's understanding, mental processes and actions. In this space, Rachel could process and integrate the therapist's feedback, challenge her tendency toward compliance-driven behavior, and begin to cultivate the reflective capacities necessary for adaptive functioning.

By contrast, in poor-outcome cases like Nathan's, the absence of an initial epistemic match in System 1 may have hindered progression to System 2 and overall progress in therapy. Possibly due to the therapist's limited explicit efforts in fostering epistemic openness through marked mirroring and validation, Nathan might not have viewed her as a trustworthy source of knowledge. When the therapist attempted mentalizing work by offering new perspectives on Nathan's issues and encouraging him to reflect on his emotions (*"It's not surprising that you are so angry at her, if you feel you have been there for her all the time"*), the therapist's mentalizing stance toward Nathan's feelings and thoughts did not appear to resonate with Nathan's subjective inner experience. Instead of engaging with this perspective, Nathan responded vaguely: *"I don't know … I mean, I guess, maybe?"* This seemed to leave him confused about the therapist's intentions and insights. His hesitance to reflect further on the therapist's words became clearer when he later stated, *"I don't really trust most people. My mom let me down, and after that … I just don't trust anyone anymore. I tried, but I can't."* Nathan remained emotionally distant and continued to emphasize his inability to trust: *"I can't trust anyone but myself."* This pattern suggests that, without the foundational epistemic match established in System 1, Nathan might have struggled to find the therapist's reflections relevant or meaningful. Instead of fostering greater self-understanding, these interventions appeared to heighten Nathan's confusion about himself and others, which might have contributed to the worsening depression symptoms and the emergence of suicidal thoughts reported in later sessions.

Communication system 3: Re-emergence of social learning outside therapy. After progressing through the first two phases, all good-outcome cases demonstrated a pattern of re-emergence of social learning, where patients appeared to apply new insights received from the therapeutic communication to their social environment outside the therapy. This shift was often marked by explicit efforts to repair relationships, form new connections, or pursue social activities that seemed to foster change and personal growth. This included actively re-evaluating relationships, seeking new social experiences, and taking steps to participate more constructively in their communities.

For example, Rachel demonstrated these shifts in several ways. She described reconnecting with her sibling to explore their thoughts and feelings about her, which she later extended to a cousin. By the mid-to-late stage of treatment, Rachel spoke about actively learning to view her relationship with her mother differently, a process that seemed to contribute to her growing understanding of interpersonal dynamics. She also began volunteering, an activity she described as deeply fulfilling, and she expressed excitement about planning social activities, such as attending a friend's birthday party, a university lecture, and taking on additional voluntary roles. By the end of therapy, Rachel expressed enthusiasm about her future, describing herself as someone who values and enjoys meaningful relationships.

Alice, while showing less improvement in mentalizing capacity compared to Rachel, also demonstrated a growing capacity for social learning and engagement. In the later stages of treatment, she expressed a desire for a *"reset"* in her life, articulating plans to apply for college and describing this as an

opportunity to grow and move forward. She remarked, *"I think it might be good to get a fresh start [...] I think it's time to grow up. I think I just want to grow up and do my own thing."* By the end of therapy, Alice mentioned applying for jobs, and described getting along better with her father.

The emerging confidence observed in all four good-outcome cases may reflect a readiness to engage with their social environment openly and constructively, potentially indicating a meaningful shift from their previously self-imposed isolation toward epistemic trust. However, re-emergence of social learning does not imply indiscriminate engagement with all relationships. Instead, patients seemed to selectively attend to relationships and social experiences they found beneficial, demonstrating an adaptive and reflective approach to their social environments.

Conversely, poor-outcome cases did not exhibit this pattern of social learning. Edith, despite being treated by the same therapist as Cora, retained a mistrustful perspective, describing herself as *"a quite unsociable person"* and continuing to view social connections as unreliable and irrelevant to her life. Similarly, Nathan showed no significant changes in his social interactions or outlook, maintaining a sense of confusion and mistrust throughout treatment. These cases underline the importance of the earlier systems—particularly establishing epistemic openness in System 1 and fostering reflective capacity in System 2—as precursors to successfully engaging in the re-emergence of social learning.

In summary, the re-emergence of social learning outside therapy appears to represent a crucial outcome of the therapeutic process for good-outcome cases. It reflects not only the internalization of insights gained through therapeutic work but also the application of these insights to relationships outside the therapy setting and their wider social environments. By selectively engaging with meaningful social connections and activities, patients demonstrate their restored capacity for epistemic trust, enabling adaptive social learning and fostering continued personal growth beyond the therapy setting.

Comparison of Successful and Unsuccessful Cases for Theory Refinement

Each case provided multiple points of connection between observed therapeutic interactions and the theoretical model, enabling a detailed synthesis of theory and practice. This refined model underscores that establishing epistemic trust may depend on creating an initial epistemic match within the therapeutic relationship, potentially providing a foundation for subsequent progress. In good-outcome cases, effective communication in System 1 appeared to allow patients to perceive the therapist as a trustworthy source of knowledge, fostering an openness to learning. This led into system 2, where patients adopted a mentalizing stance, deepening their reflective capacity and emotional insight. System 3 then emerged as patients began to generalize these new perspectives to their broader social interactions, engaging with their environment in more adaptive ways. In this sense, the progression from System 1 to System 2, and then to System 3, is sequential, as each system builds on the previous one and serves as a necessary pre-condition for the next.

However, we also observed that Systems 1 and 2 were frequently revisited in later systems. For example, the return to marked mirroring and ostensive cues in System 1 often supported the patient in enhancing their capacity for mentalizing while also addressing or challenging non-mentalizing behaviors (e.g., rigid, overly concrete, or dismissive interpretations). This demonstrates how System 1 remains relevant and active, even as patients progress through other systems. In this way, the three communication systems also operate in parallel, with earlier systems remaining active and interconnected with later ones. This dynamic interplay highlights the non-linear, iterative nature of the process, aligning with Fonagy et al.'s (2015, 2017, 2019) framework.

The poor-outcome cases demonstrated that sustained epistemic mistrust may arise when early sessions seemed to lack a sufficient epistemic match, where the therapist recognizes and validates the patient's subjective experience through marked mirroring. This epistemic match is suggested to foster epistemic openness, potentially laying the foundation for the patient to engage with new perspectives offered by therapists in later phases of the treatment, a process that appears to be essential for therapeutic change and growth.

In Nathan's case, the therapist's initial approach lacked the marked mirroring and validation that might have helped him feel more understood. Instead, the therapist remained mostly quiet and responded minimally to his early disclosures, offering short prompts like *"Oh yeah?" "You think?"* This reserved approach might have reduced opportunities to use relevant cues to convey therapeutic communication as helpful and personally meaningful to Nathan, thus leaving him without a clear sense of purpose in the therapy. Consequently, this might have prevented Nathan's perception of the therapist as a trustworthy source of personally relevant knowledge, potentially undermining his openness to engage with the therapeutic process.

When Nathan attempted to gauge the therapist's trustworthiness and the therapy's relevance, either

consciously or unconsciously, by asking the therapist personally relevant questions—such as *"How long have you been working as a psychotherapist?"* and *"Do you have any children?"*—the therapist responded with deflective questions, like *"How long do you reckon?"* and *"What do you think?"* While such responses could be part of a therapeutic strategy, Nathan appeared to be further confused by these. In the absence of explicit, aligned answers, Nathan's engagement waned, as he might have struggled to see the therapist as a reliable and trustworthy figure.

In later sessions, the therapist began to adopt a more reflective stance and offer occasional marked mirroring, as when the therapist observed, *"So you felt responsible again for the adults?"* These communications provided some moments of validation, but by this point, without an already established epistemic match, Nathan appeared unreceptive to the therapist's insights. Similarly, the therapist also attempted to link Nathan's current feelings of the therapeutic relationship to past experiences with his mother, but Nathan did not seem receptive to this exploration. Instead, his depressive symptoms worsened over time, and he reported suicidal thoughts in session five.

In Edith's case, the therapist's structured intervention, which had proven effective for Cora, did not resonate in the same way, possibly due to Edith's entrenched mistrust of social communication. Despite working with both patients, the therapist's approach led to contrasting outcomes, highlighting the importance of highly individualized, moment-to-moment matching in therapy. The therapist provided Edith with psychoeducation and tailored advice aimed at recognising and improving her social and mental habits. For example, the therapist validated Edith's inner experience by saying, *"You have understood that a trouble shared is better than it is bottling up. You got into a real bottle-up stage,"* providing marked mirroring that acknowledged her tendency to keep feelings inside. However, Edith remained emotionally detached, continuing to describe herself as *"a private person," "a solitary person,"* and expressing sentiments like, *"I'm not a forgiving person. I always remember things."* These statements reflected her persistent skepticism toward the idea of trust in the social world and suggested that she viewed connections with others as unreliable.

Throughout therapy, Edith continued to uphold her belief that relationships were generally unhelpful, rejecting the therapist's encouragement to reconnect with friends or family as something of limited value. This resistance suggested that the therapist's communications, though understanding and empathetic, may not have established the deeper epistemic resonance required to fully match Edith. While structured advice and psychoeducation early on were useful for Cora, Edith's response indicated that she may have benefitted from a slower, more gradual approach with longer sessions that prioritized building an epistemic match before advancing toward robust mentalizing and action-oriented recommendations. The absence of a fully realized epistemic match in Edith's sessions may have reflected her reservations and limited her readiness to benefit from therapeutic communication. Edith's case highlights the importance of achieving a dyadic match, wherein the therapist flexibly tailors communication to align with the patient's moment-to-moment openness.

Moreover, unlike Cora, whose mother actively participated in therapy sessions with a reflective stance and was a consistent source of support and care in daily life, Edith felt uncared for and unsupported by any of her family. Despite ongoing encouragement from the therapist to identify supportive figures, Edith did not perceive or disclose any positive influences in her social environment, regardless of whether such figures may have actually existed. While it may not be meaningful to directly compare the challenges of Edith's and Cora's social environments or their individual resilience, the contrast between their cases suggests that the success of building epistemic trust may not only depend on the therapist's approach, but also on the patient's readiness and the degree of support and safety in their environment.

Overall, the absence of an initial epistemic match in both poor-outcome cases may have hindered Nathan's and Edith's ability to perceive the therapist as a trustworthy source of knowledge, failing to trigger the epistemic openness required to engage with what was communicated as relevant and contributing to poor treatment outcomes. These cases highlight the importance of early foundational elements—such as marked mirroring and relevance cues—in fostering a trusting relationship where social learning can occur. In sum, we conclude that resolving epistemic mistrust may depend on the therapist's timely use of relevance cues and communicative signals, as well as the patient's readiness, which is potentially influenced by the supportiveness of their social environment.

Discussion

This study used theory-building case study methodology to test and refine the three communication

systems theory (Fonagy et al., 2015, 2017, 2019) for resolving epistemic mistrust and building epistemic trust in psychotherapy, drawing on clinical data from adolescents undergoing brief psychological treatment for depression. Through detailed case comparisons, a refined framework emerged that integrates essential therapeutic processes for resolving epistemic mistrust. The three communication systems reflect a sequential yet iterative process of therapeutic engagement. In System 1, the therapist's timely use of relevance cues and communicative signals establishes an epistemic match, which triggers epistemic openness by signaling and positioning the therapist as a reliable source of knowledge. In System 2, as the patient views the therapist as a trustworthy source of new knowledge and enters a learning relationship, they become receptive to new insights from the therapist, enabling them to revise and expand their original mentalizing processes. System 3 extends these therapeutic gains to broader social interactions, enabling patients to apply new perspectives proactively and adaptively. Despite their sequential progression, the systems frequently operate in parallel, with earlier systems revisited to reinforce and support progress in later stages, highlighting the dynamic and interconnected nature of the process. While the findings suggest potential patterns of dependency between communication systems (e.g., System 1 creating conditions for System 2), these observations remain exploratory. The interconnections observed in this study highlight the importance of foundational therapeutic elements in resolving epistemic mistrust, but further research is required to confirm these relationships and their broader applicability.

Our findings build on and extend Fonagy et al.'s theory (2015, 2017, 2019) by providing preliminary empirical support while also contributing three additional insights. First, an early "window of opportunity" exists during which an epistemic match is likely to play an important role, as this match may signal that the therapist is a trusted source of relevant insight and is thought to be necessary for encouraging epistemic openness, ideally occurring early in treatment, not merely ahead of System 2. Second, while the identified model components are thought to be necessary, they may not be sufficient—enduring change may also depend on the presence of supportive interpersonal experiences outside therapy, which may play a role in sustaining and extending therapeutic progress. Third, the interactive nature of the therapeutic process suggests that resolving epistemic mistrust may also involve not only the essential components identified in the model and the therapist's efforts but also the patient's engagement, which may be supported by increasing therapist responsiveness to foster a more collaborative dynamic.

Epistemic Openness and Trust and Therapeutic Bond and Alliance

The process of resolving epistemic mistrust and building epistemic trust in psychotherapy aligns closely with Wampold's (2015) model which suggests that therapeutic benefits arise through an initial therapeutic bond, a real relationship, the creation of expectations through explanation of disorder and the treatment involved, and the enactment of health promoting actions. Our findings suggest that Communication System 1, emphasizing epistemic match and openness, may reflect Wampold's initial pathway: forming a bond in which the patient evaluates the therapist's trustworthiness and competence in early sessions. This phase is proposed as foundational for fostering openness, as patients must feel understood and see the therapist as reliable before engaging in deeper reflective work. This foundational phase appears to enable progress to System 2, focusing on increased mentalizing, which may align with Wampold's subsequent pathways, where a genuine therapeutic relationship and shared explanations for coping with difficulties are collaboratively built. Finally, in System 3, re-emerged social learning (i.e., reconnecting with and learning from others) outside of therapy can be seen as reflecting Wampold's enactment of health-promoting actions, as patients begin to apply therapeutic insights to their wider social lives beyond the here and now of the psychotherapeutic encounter.

Wampold's (2015) model emphasizes that the alliance between therapist and patient is a primary mechanism for therapeutic change. Within the context of the therapeutic alliance, we propose that epistemic openness acts as a precursor to its development, while epistemic trust emerges as an outcome of this collaborative process. As outlined by Bordin (1979), the therapeutic alliance consists of three interconnected components: the bond between therapist and patient, and agreement on tasks and goals. We believe that epistemic openness develops in parallel with the bond, and both are supported through the process of collaboratively identifying relevant therapeutic tasks and meaningful goals, achieved through the therapist's attuned use of the therapeutic model. This agreement on tasks and goals provides one of the main pathways for achieving an epistemic match—a shared understanding that communicates to patients that their therapist sees and understands their experience. More specifically, this alignment serves two critical functions:

first, it allows patients to feel that their subjective perspective is recognized and validated; second, it demonstrates the usefulness of the therapeutic model in making sense of their specific difficulties. Together, these two components foster epistemic openness, as the patient begins to view the therapist as a reliable and personally relevant source for learning.

Built upon this foundation of epistemic openness, the therapeutic alliance is established and serves as the foundation for epistemic trust. This shift, where patients begin to extend this perspective to others outside of therapy, occurs for two key reasons. First, as the therapeutic model proves effective in explaining their challenges, patients gain greater clarity about their difficulties and develop alternative ways of viewing their problems and their social world. Second, as patients begin to believe that others can provide useful and relevant information, their natural human capacity for social learning—essential for adaptation and growth—is restored. Together, these processes help to restore epistemic trust, enabling the patient to re-engage with their social world in new and more adaptive ways.

In this way, the therapeutic alliance demonstrates that treating others as reliable sources of social learning can be beneficial. Over time, we argue that this process fosters epistemic trust, which extends beyond the therapist to reflect the patient's renewed capacity to believe others—and the social world more broadly—as potential sources of new, relevant knowledge. In our view, the therapeutic alliance serves as an outstanding example of a relationship that models the value of trusting others and learning from social interactions. This perspective aligns with Wampold's (2015) model, where the therapeutic bond and collaboratively developed tasks and goals build a foundation for change.

The Window of Opportunity: Establishing an Early Epistemic Match

Nathan's case suggests there is a critical window early in treatment for establishing an epistemic match, which may be necessary for triggering epistemic openness. This match, which could signal that the therapist is a trusted source of relevant insight, must occur early, not merely ahead of System 2. This window of opportunity may be particularly critical in short-term treatments and when working with adolescents, where establishing trust and fostering epistemic openness early in the therapeutic process can significantly influence engagement and outcomes. Given the inherent power differential that characterises the psychotherapeutic encounter, patients are often vigilant for signs of untrustworthiness at the early stage of treatment (Brennan et al., 2013). Missed opportunities for establishing an epistemic match early in treatment may lead to perceived trust violation, where unmet expectations can prompt the emergence of previously established thinking patterns leading to negative evaluations of the other's integrity, ability, and intentions, sometimes leading to complete distrust. In Nathan's case, the therapist's evasive responses and neutral attitude may have come across as incompetence or insincerity, creating epistemic mismatches that eroded Nathan's perception of her as a reliable source of knowledge. While the therapist later attempted mirroring Nathan's inner states and supporting him to mentalize his subjective experience, Nathan did not adopt this stance or develop new insights into his struggles. This potential ineffectiveness of the therapist's mentalizing efforts might be traced to the absence of early validation and relevance cues that could have contextualized Nathan's subjective experiences within the therapeutic model and allowed him to perceive and internalize the therapist's knowledge within the therapeutic framework.

While the therapist's use of silence aligns with psychodynamic approaches (Bateman & Holmes, 1995), where neutrality gives space for patient expression (Hill et al., 2003), this style may not have matched Nathan's needs. Adolescents, in particular, often interpret prolonged silence as a sign of disinterest or emotional disengagement, which can increase feelings of alienation or mistrust in therapy (Lane et al., 2002; Roberts et al., 2011). Research shows that therapists who are actively engaged, focused, and encourage patient participation yield better outcomes, regardless of therapy type (Duncan et al., 2004; Holdsworth et al., 2014; Norcross, 2002). Moreover, literature on adolescent psychotherapy underscores the importance of tailoring interventions to meet young patients' developmental needs over strict adherence to therapeutic models (Briggs, 2002; Verduyn et al., 2009). Notably, the same psychodynamic model was applied differently in Alice's case—with her therapist actively engaging her inner world and working through defensive processes—resulting in a successful outcome. All of this together suggests that the critical factor may not be the therapeutic model itself, but rather *how* the therapist adapts and applies it to meet each patient's moment-to-moment needs, that determines the effectiveness of psychotherapy (Roos & Werbart, 2013) and contributes to resolving epistemic mistrust.

Moreover, the concept of an early "window of opportunity" is supported by research on therapeutic

alliance. A strong working alliance early in treatment is often crucial, as early alliance predicts engagement and positive outcomes (Anderson et al., 2009; Nissen-Lie et al., 2021; Kivlighan & Shaughnessy, 2000). Evidence indicates that this alliance can emerge even within the first session (Kokotovic & Tracey, 1990), and poor alliance in early sessions can predict later dropout (O'Keeffe et al., 2020). Nathan's case also exemplifies the critical role of rupture and repair in the development of epistemic openness and trust. Alliance ruptures—often arising from a misalignment in the bond, tasks, or goals of therapy (Safran & Muran, 2000)—can be particularly detrimental for patients entering treatment with epistemic mistrust, as unresolved ruptures in the early stage of treatment can prevent openness from developing. In Nathan's case, the therapist may have been perceived as passive and lacking responsiveness. This may have lacked the attuned relational signals, marked mirroring, or relevance cues necessary to establish an epistemic match, potentially contributing to ruptures in the therapeutic relationship as Nathan interpreted them as disinterest or insincerity. Such early ruptures hinder the patient's ability to view the therapist as a trustworthy source of learning, obstructing the development of epistemic openness needed for therapeutic progress. Although the therapist later attempted repair, Nathan's continued disengagement suggests that the rupture may have already undermined his ability to view the therapist as a reliable source of new knowledge. Fonagy et al. (2023) emphasize that successful repair requires reestablishing "we-ness"—a shared understanding that fosters mentalizing and alignment—a process that the therapist in Nathan's case did not appear to prioritize. This underscores the importance of the early therapeutic window for resolving ruptures timely, as unresolved breakdowns at this stage can obstruct the development of epistemic openness and engagement, thus potentially undermining treatment effectiveness.

Beyond Therapy: The Role of Supportive Environment

In both poor-outcome cases, Nathan and Edith, the missed opportunity to establish epistemic openness early in therapy may have constrained their capacity for therapeutic engagement and ultimately impacted their treatment outcomes. However, unlike Nathan, whose therapist appeared more passive and less responsive to his specific needs, Edith's therapist adopted a more active role. This difference suggests that, while Nathan may have benefited from the therapist taking a more engaged and active stance, Edith might have required a slower, more gradual process to establish an epistemic match. This need for a prolonged approach may be influenced by Edith's social environment, potentially affecting her readiness to engage fully in therapy.

Unlike Cora, the essential patient engagement in the three communication system was not evident in Edith's case, indicating that completing all therapist-led activities alone is not sufficient to resolve epistemic mistrust. Importantly, previous studies suggest that factors like higher baseline depression, comorbid symptoms, and family and contextual influences (e.g., race, ethnicity, trauma history) can contribute to nonresponse in adolescent depression (e.g., Curry & Meyer, 2020; Davies et al., 2020). Edith might exemplify epistemic petrification, a heightened form of epistemic mistrust where individuals, often due to adverse developmental histories and life impairments, are less able to change their epistemic stance through interpersonal interactions. For example, adolescents with a history of early childhood maltreatment may struggle to recognize trustworthy adults compared to those without abuse histories (Jernbro et al., 2017), or defensively inhibit their curiosity about other peoples' minds (Salaminios & Debbané, 2021). It is possible that Edith lacked the capacity to accurately interpret ostensive cues from the therapist. For instance, the therapists' attempts to mirror Edith's inner states may have conflicted with her strongly held mental representations of herself and others, preventing her from perceiving the therapist's intentions as benign. While Cora also faced challenges, she appeared to have begun therapy with a relatively greater pre-existing mentalizing capacity, which allowed her to engage with the therapist.

Edith's ongoing difficulty may have been compounded by her current social environment outside therapy. Studies show that external factors can account for up to 40% of therapeutic outcomes (Norcross & Lambert, 2019), with better social support correlating with improved depression outcomes (Lindfors et al., 2014; Trivedi et al., 2005). While Edith and Cora shared the same BPI therapist, their family experiences differed; Cora described a critical but somewhat supportive environment, whereas Edith lacked this. In Edith's case, adverse experiences within her current social environment may have potentially undermined the development of epistemic trust within the therapy relationship. As a result, the therapist's impact may not have been sustained, making therapeutic change less likely. This aligns with Fonagy et al.'s theory (2015; 2017; 2019) that the ability to access a relatively benign social environment may be crucial for building and sustaining epistemic trust. For patients

living in highly deprived, isolated, or abusive environments, the therapist's interventions may feel disconnected from their lived experience outside the consulting room, making it difficult to integrate therapeutic insights into their external life.

The Interactive Nature of the Key Process: Therapist Responsiveness

Moreover, the two poor-outcome cases highlight the interactive nature of the key processes in our model of resolving epistemic mistrust. Differences between good- and poor-outcome cases stem from both therapist and patient contributions, evident in patient–therapist interactions. Studies on patient–therapist match conceptualize it as underpinned either by static factors, like shared cultural values, or a dynamic process developing over time (e.g., Dolinsky et al., 1998; Vaughan & Roose, 2000). This underscores that psychotherapy functions as a two-person, rather than a one-person, system, unique to each patient–therapist dyad. This is especially clear when comparing the cases of Edith and Cora, who were treated by the same therapist but demonstrated contrasting therapy processes and outcomes. While Cora might have perceived the therapist as persuasive, fostering an engaging relationship where both actively contributed to the therapeutic process, Edith might have experienced the therapist's approach as dominating or even intrusive on the basis of her readiness to engage at that level of depth or pace. For Edith, the therapist's questions may have felt misaligned, giving the impression that the therapist presumed a greater understanding of her mind than she herself could recognise. Thus, what appeared to be a collaborative process with Cora may have felt, to Edith, like a therapist-dominated and often confusing dialogue.

Effective patient-therapist match may depend on therapist responsiveness – the ability to adjust therapeutic approaches to meet the patient's evolving needs (Stiles et al., 1998; Stiles & Horvath, 2017). Responsiveness involves not only reacting to the patient's needs but also interpreting and responding to patient coaching behaviors, that is, any patient-initiated communication intended to help the therapist understand their therapeutic goals, obstructive beliefs, and preferences for therapy style (Bugas & Silberschatz, 2000; Weiss, 1993).

In Edith's case, the therapist's attempts at engagement, while well-intentioned, might not have fully aligned with Edith's emotional needs or responded adequately to her therapeutic cues. Despite the therapist's active approach, Edith's entrenched mistrust of others, particularly in the context of her family relationships, may have made it difficult for her to accept or internalize the therapist's interventions. The structured approach that appeared to be effective for Cora might have felt less attuned to Edith's moment-to-moment emotional needs. While the therapist seemingly attempted to validate Edith's experiences—such as acknowledging her tendency to bottle up emotions—these interventions were often met with emotional detachment or resistance. Additionally, the therapist's emphasis on psychoeducation may not have aligned with Edith's readiness or willingness to engage at that moment, suggesting that the pace and depth of intervention might have required further adjustment to match her emotional state and social context. Thus, from the perspective of therapist responsiveness, the therapist's approach might not have been sufficiently adapted to Edith's evolving emotional needs and therapeutic goals. This possible misalignment may have contributed to a missed opportunity to establish the epistemic match necessary for fostering epistemic openness.

Likewise, in Nathan's case, the therapist's adherence to a traditional psychodynamic approach, marked by long silences and passivity, may not have met Nathan's need for a more interactive and supportive interaction. While silence can sometimes be a useful therapeutic tool, in this case, the therapist's minimal verbal engagement may not have responded adequately to Nathan's implicit or explicit coaching behaviors—such as his frustration, uncertainty, or need for reassurance—which could have signaled a desire for more interactive or validating interventions. Without sufficient responsiveness to these cues, Nathan may have felt misunderstood or disengaged, ultimately leading to premature termination of therapy.

Both poor-outcome cases illustrate challenges in therapist responsiveness, where the therapist's approach may not have been sufficiently adapted to the patient's evolving emotional needs, therapeutic goals, or preferred therapy style, limiting therapeutic effectiveness. Kealy et al. (2022) observed that limited therapist responsiveness to patient coaching behaviors correlated with treatment failure, as reflected by minimal symptom improvement and early termination. Thus, therapist responsiveness—including the ability to recognize and adjust to patient coaching behaviors—is likely especially crucial in the early stages of therapy for fostering the interactive dynamics necessary to establish an epistemic match and create epistemic openness.

Clinical Implications

This theory-building case study approach does not aim to determine *which* therapeutic models are most effective in resolving epistemic mistrust but rather emphasizes that *how* a model is delivered as

the critical factor. Therapists should act promptly and empathically in the early sessions to establish an epistemic match, especially for patients starting with high epistemic mistrust. Therapists across orientations may need training in techniques that actively build trust early on, as some level of epistemic openness is essential for any therapeutic change. Those practicing psychodynamic or psychoanalytic approaches might particularly benefit from acquiring active techniques to ensure trust is fostered effectively. Therapists should also carefully assess each patient's readiness before advancing through the therapeutic stages. Silberschatz (2021) underscore the importance of tailoring therapy to each patient's unique therapeutic goals and preferred styles, which aligns with the responsive, adaptive process identified in our case study model. Effective therapists should be skilled in creating an epistemic match early on, monitoring patients' acceptance of new insights, and adjusting delivery accordingly.

Moreover, while this study focuses on psychotherapy for depression, epistemic mistrust may be a transdiagnostic phenomenon, present across various mental health conditions, such as borderline personality disorder (Fonagy et al., 2017; Knapen et al., 2025) and PTSD and complex PTSD (Kampling et al., 2022). These difficulties are particularly evident in conditions involving childhood adversity and trauma, where disruptions in epistemic trust can be traced to adverse early experiences. For patients with deep-seated mistrust or high levels of general psychopathology (the "p" factor), gradual progress in a longer treatment may be more realistic, as creating openness in System 1 may require a more extended and sensitive approach. Longer treatment durations have been associated with better outcomes for depression (Păsărelu et al., 2017), and those with limited social support and adverse attachment histories may particularly benefit from therapists who can establish strong alliances and provide additional support beyond traditional treatment (Wampold, 2015). Given its relevance across multiple conditions, the three communication systems framework may offer a useful therapeutic approach to fostering epistemic openness and sustaining therapeutic engagement in individuals with histories of trauma, attachment disruptions, or persistent interpersonal mistrust.

Limitations

This theory-building study is an initial empirical effort to understand ways of resolving epistemic mistrust and building epistemic trust in psychotherapy. However, the findings should be considered within the context of several limitations. First, the theory-building case study approach prioritizes exploration and refinement of theoretical frameworks over establishing causal relationships. While the findings provide valuable insights, they should be interpreted as illustrative rather than definitive. Although our findings suggest possible pathways for resolving epistemic mistrust, broader empirical studies using different methodological designs would be required to assess these hypotheses across varied clinical samples and treatment contexts. The model's components, such as the window of opportunity, environmental influence, and interactive nature, need validation with quantitative measures, such as pre- and post-session self-reports, across a larger sample to determine their general applicability and transferability. As our findings provide rich, detailed descriptions of specific cases, they offer insights that may be applicable to similar clinical contexts, but further research would be needed to confirm these insights in broader populations. While the findings suggest valuable patterns, they do not claim generalizability in the traditional sense of statistical inference.

Another challenge within the theory-building approach lies in the subjective nature of analyzing complex patient-therapist interactions. Since this study was based on detailed observations of a limited number of cases, the interpretations of these interactions may be influenced by the researchers' perspectives and theoretical orientation. The findings are, therefore, exploratory and invite further study to substantiate or refine the observed dynamics. Additionally, our study's reliance on qualitative observations and audiotaped recordings presents some limitations. While audiotapes provided valuable insights into patient-therapist interactions, videotaped recordings could have offered additional non-verbal data, enriching our understanding of the dynamics involved. Future research could benefit from multimodal recordings to capture a fuller picture of the therapeutic process.

Finally, it is essential to emphasize that the resulting model does not imply causation at multiple levels. Adhering to the steps outlined in the model does not guarantee the resolution of epistemic mistrust or the establishment of epistemic trust. Likewise, resolving epistemic mistrust does not necessarily equate to positive treatment outcomes. This limitation underscores the exploratory nature of our findings, indicating that establishing epistemic trust may support successful outcomes but may not be directly causative. Thus, while our study offers a qualitative exploration within the three-communication system theory framework, we acknowledge that further empirical studies are

needed to assess the transferability and broader applicability of these insights.

Conclusions

This theory-building case study provides preliminary empirical support for Fonagy et al.'s (2019) three communication systems theory in resolving epistemic mistrust and building epistemic trust in psychotherapy. This study also refines and enriches the theoretical model by integrating empirically observed therapist and patient behaviors within the three systems, which potentially provides therapists with prognostic indicators for tracking the resolution process. Beyond supporting the original theory, this work adds three key contributions: the notion of an early "window of opportunity" where an epistemic match is critical for fostering openness; the recognition that supportive relationships outside therapy may be vital for sustaining progress; and the importance of patient engagement, alongside therapist responsiveness, in creating a collaborative therapeutic process. While this qualitative analysis offers meaningful insights, further research is needed to validate these patterns in larger and more diverse samples. Future studies should also explore how epistemic trust develops in cases where therapists deviate from the model but patients still achieve progress.

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