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Faculteit Geneeskunde en Levenswetenschappen
School voor Levenswetenschappen

master in de biomedische wetenschappen

Masterthesis

Epistemic trust among youth and young adults with severe mental health illnesses during their transition to adulthood: A qualitative study

Mathilde Bironf

Scriptie ingediend tot het behalen van de graad van master in de biomedische wetenschappen, afstudeerrichting klinische biomedische wetenschappen

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Epistemic trust among youth and young adults with severe mental health illnesses during their transition to adulthood: A qualitative study*

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**Epistemic trust in youth: qualitative research*

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Keywords: Epistemic trust, Psychotherapy, Transition psychiatry, Outreach treatment, Therapeutic relationship, Semi-structured interview.

ABSTRACT

Epistemic trust (ET), the capacity to accept information from others as relevant, reliable, and personally meaningful, is essential for therapeutic change. Previous research highlights the role of ET in clinical populations, but its development and recovery in therapeutic contexts remain underexplored. This is particularly important during adolescence and young adulthood. These developmental phases involve major psychological, emotional, and relational transitions while ET is still forming. This qualitative study aimed to investigate how ET is built, challenged, and restored within the therapeutic relationship in an outreach team for adolescents and young adults with severe mental health illnesses. Twelve semi-structured interviews were conducted with participants aged 18-24 (50% female, mean age 20.92), all of whom experienced significant psychological distress and showed complex psychiatric profiles. Using thematic analysis, five overarching themes were identified: 1) Therapist's basic attitude, including warmth, empathy, and active listening; 2) Therapist's voice as a guide, through feedback, advice, and transparency; 3) Therapy as a safe space, characterized by professionalism and knowledge of the therapist; 4) Recognition as a unique individual, with honest validation beyond diagnostic labels; and 5) Rupture and repair, highlighting the importance of acknowledging and restoring relational breaks. The themes were present across all interviews. These findings underscore the importance of basic therapeutic behavior in fostering ET. Further longitudinal research is needed to understand how ET evolves and can be restored in patients who disengage from therapy.

INTRODUCTION

Epistemic trust (ET) refers to the predisposition of a person to accept and trust that the information of others is authentic, trustworthy, generalizable, and relevant to themselves [1]. It plays a critical role in knowledge acquisition, social learning, and personal development, as it enables individuals to selectively and appropriately engage with opportunities for social learning. Additionally, it facilitates the integration of new information into existing knowledge structures and supports the development of resilience in challenging contexts [2-5]. ET disruption, termed epistemic mistrust (EM), describes a state in which individuals tend to perceive sources of information as unreliable or malicious, leading to resistance to social learning and avoidance of influence from others. In contrast, epistemic credulity (EC) reflects an inability to distinguish trustworthy from untrustworthy information, heightening susceptibility to misinformation and exploitation. These phenomena are particularly significant in psychotherapy, as the capacity to establish ET with a therapist is critical for openness to new perspectives and adaptive knowledge transfer [3, 4, 6, 7]. To resolve EM and establish ET in psychotherapy, therapists must communicate in line with Fonagy *et al.*'s theory of the three communication systems [9-11]. This framework consists of three interconnected steps. The first system involves building or restoring ET by achieving an epistemic match. This means patients feel heard, seen, and understood, with therapy tailored to their unique subjective experience. A shared understanding of the patient as an intentional agent supports the therapeutic relationship between therapist

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and patient. These conditions can help patients become more open over time [6, 8-12]. The second system focuses on enhancing the patient's capacity to mentalize, meaning the ability to reflect on the mental states (thoughts, feelings) underlying their own and others' behaviors. As this capacity strengthens, patients may come to see themselves and others in new ways, potentially creating a shared "we-mode" between therapist and patient [6, 8-12]. The third system involves the re-emergence of social learning. This enables patients to engage actively with their social environment outside of therapy. It includes forming or preparing for new relationships, redefining existing ones, and applying therapeutic insights to strengthen their broader social world. These three systems are mutually reinforcing and build upon one another, but the process is not strictly linear. It is essential to revisit and repeat these systems throughout therapy, as they often operate parallel [6, 8-12].

Approximately half of all mental health disorders emerge by the mid-teens, with three-quarters occurring before age 25. Early-onset conditions often evolve into more severe disorders, underscoring the importance of early interventions to mitigate their severity and persistence and to prevent secondary disorders [13, 14]. Adolescence is a critical period characterized by significant developmental challenges such as gaining independence, making decisions about education and career, and forming personal identities. These transitions can create stress and test adaptability but offer opportunities for growth and the potential to overcome these challenges [15]. Mental health problems during adolescence can have long-lasting effects, including isolation, reduced life satisfaction, impaired social functioning, and a lower health-related quality of life in adulthood [14, 16]. ET is still developing during adolescence, making this a critical period for investigation. Adolescents with severe mental health illnesses show reduced ET, which can hinder developmental progress and limit engagement in treatment. Studying ET across diverse adolescent populations is therefore essential to understanding its developmental trajectory and further refining the model of ET within developmental psychopathology [6, 17].

Research indicates that examining ET in patients with severe mental health illnesses provides valuable insights into the factors influencing ET. Such knowledge can inform the development of more effective strategies for enhancing mental health, fostering a stronger therapeutic relationship, and improving treatment outcomes [6, 7, 18]. ET is central to the therapeutic process, as therapy relies on an adolescent's openness to the therapist's input. Many adolescents who enter therapy have experienced interpersonal problems in their personal relationships and treatment. This has led to increased EM, or hypervigilance, making them less willing to cooperate or accept guidance [Pers. Comm.]. However, further research is required to explore these issues within adolescent clinical populations, particularly concerning psychotherapy outcomes and therapeutic relationships [4, 6].

Recent research has highlighted the importance of ET in psychotherapy. Yet, to the best of our knowledge, studies directly exploring ET within therapeutic contexts remain limited. Existing research has primarily relied on questionnaires, such as the Epistemic Trust, Mistrust, and Credulity Questionnaire (ETMCQ), to assess ET. For instance, Riedl *et al.* (2023) demonstrated that good performance during psychosomatic rehabilitation is linked with improvements in ET in adults, while heightened EM and EC were associated with poorer performance [19]. Fonagy *et al.* (2014) proposed that mentalization facilitates the development of ET between the patient and the therapist. This makes patients feel understood during therapy, further restoring ET and mentalizing [7]. However, self-report questionnaires have limitations, as they are susceptible to various biases, such as social desirability bias and limited self-awareness [20, 21]. Additionally, self-report questionnaires do not permit an in-depth exploration of participants' experiences and underlying mental states. Patients may misinterpret the questions, or their responses may not accurately reflect their personal views. Furthermore, as these questionnaires typically consist of fixed-choice items, asking participants to rate predefined statements offers limited opportunity to express their thoughts and feelings [21].

To date, only a few studies have specifically investigated ET and EM in the context of individual psychotherapy experiences using qualitative data. Thomas *et al.* (2019) and Folmo *et al.* (2019) identified ET as a core theme of mentalization-based therapy (MBT), emphasizing the importance of a safe,

flexible, and therapeutic space. Their studies focused on adults with antisocial and borderline personality disorder, respectively. Further, Folmo *et al.* (2019) proposed that ET may develop through repeated experiences of the therapist being professional and supportive [6, 17, 22, 23]. However, these studies did not directly examine how individuals personally experience the process of gaining or rebuilding ET in psychotherapy [6, 22, 23]. Jaffrani *et al.* (2020) observed stages of ET restoration in an adoptive family receiving MBT, highlighting the importance of empathy, respect, and a secure therapeutic relationship [6, 17, 24]. This study was limited by its single-case design involving one specific family context [6, 24]. Li *et al.* (2022) explored ET dynamics in depressed adolescents, finding that a shift from EM to ET was associated with improved therapy outcomes. However, these shifts were not universal and depended on interpersonal components within and beyond therapy. Positive therapist behaviors, such as demonstrating expertise and empathy, foster good therapeutic relationships and can contribute to a transition from EM to ET. Beyond treatment, social environments may be key in promoting ET, particularly for some young individuals [6, 17]. Nevertheless, the method used in the study was developed retrospectively, and no formal assessment of EM was conducted before the start of therapy. The analysis primarily focused on general change processes rather than examining specific causal links between therapists' interventions and changes in ET. Furthermore, the study included only adolescents diagnosed with depression without considering broader psychiatric presentations [6]. However, Li *et al.* (2025) did an additional study where they conducted a theory-building case study to investigate how EM is resolved and how ET is established in psychotherapy for depressed adolescents. They analyzed therapy recordings from six selected cases using a combination of deductive, inductive, and abductive reasoning. Their analysis mapped therapist and patient behaviors onto the theory of the three communication systems, identifying patterns that supported or challenged its assumptions. Key findings included the importance of an early epistemic match, the role of external supportive relationships, and the dynamic interplay of therapist responsiveness and patient engagement. This study refined the theoretical model by empirically identifying markers of epistemic shifts, offering preliminary prognostic indicators for therapeutic progress. However, limitations include the small and non-representative sample, which makes generalizability uncertain [8]. Together, these studies provide preliminary evidence linking the restoration of ET and effective psychotherapy. However, their focus on specific (diagnostic) groups and limited sample sizes restricts the generalizability of the findings across broader mental health populations. Moreover, they do not clarify how participants experience ET's development or recovery in psychotherapy, nor which specific interventions contribute to these shifts [8, 17]. This study addresses several of these limitations by exploring how ET evolves within the therapeutic relationships of adolescents and young adults with severe mental illnesses. The study uses a targeted semi-structured interview design to examine patients' perspectives of therapist behaviors and their perceived impact on ET. By analyzing their experiences, the study aims to deepen the theoretical understanding and identify concrete therapeutic interventions.

The "Mobiel Psychiatrisch Team" 15 24 (MPT 15 24), an outreach team, focuses on adolescents and young adults experiencing significant psychological distress due to severe and multiple psychiatric and psychological illnesses. These illnesses prevent them from accomplishing developmental tasks specific to their age (identity versus role confusion and intimacy versus isolation) [25]. This can affect various aspects of their lives, such as education, work, leisure activities, and social relationships. Many of these individuals have extensive prior experiences with mental health services, frequently accompanied by negative experiences. The MPT 15 24 offers an alternative to (day) hospitalization through a multidisciplinary home-based treatment program (weekly contacts). This intervention is carried out for the shortest possible time but remains available for as long as necessary. The team ensures a smooth transition to subsequent treatment providers when follow-up care is indicated.

The present study aims to explore the understanding of ET within the MPT 15 24 population by focusing on the experiences of adolescents and young adults receiving care from the team through semi-structured

interviews. The central research question is: *How is epistemic trust built, challenged, and restored through relational processes within the therapeutic relationship between adolescents and young adults and their caregivers in MPT 15 24?* The study focuses on how specific therapist behaviors are perceived to affect ET and how moments of disruption or repair are experienced.

EXPERIMENTAL PROCEDURES

Participant and recruitment – Participants in this study were adolescents and young adults aged 15–24 years with severe mental health and psychiatric illnesses. Recruitment focused on individuals undergoing treatment or those who had completed treatment within the past three months with the MPT 15 24. Inclusion and exclusion criteria were carefully defined and applied to ensure the findings are representative of the target population and generalizable to the broader MPT 15 24 patient population (Supplementary Table S1). Eligible participants were identified by MPT 15 24 staff, who also informed their legal representatives when applicable. Interested individuals received a detailed explanation of the study and were provided with informed consent documents. Participants were granted a reflection period to consider their involvement. If they agreed to participate, any remaining questions were addressed, and written informed consent was obtained from the participants and their legal representatives when necessary. Recruitment aimed for a target sample size of approximately 12 participants. This number was determined based on methodologies from similar studies, ensuring sufficient depth and variation in the data while maintaining practical feasibility. Data collection continued until information saturation was achieved.

Data collection – Data collection involved a semi-structured interview to explore the therapeutic relationship between participants and caregivers at MPT 15 24, with a particular emphasis on the role of ET during treatment. Each interview lasted approximately 95 minutes (between 53 and 137 minutes) and was conducted by the primary researcher, unfamiliar with the participants, to minimize potential bias. All interviews were recorded using *Teams* software, transcribed verbatim using *good tape* software, and prepared for thematic analysis.

The semi-structured interview guide was carefully developed to align with the study's objectives, comprising 26 questions designed to capture comprehensive insights into the therapeutic relationship. These questions were categorized into five areas, including the introduction (3 questions), positive (8 questions), and negative (7 questions) aspects of the therapeutic relationship, future aspects of the relationship within MPT 15 24 (3 questions), and unique aspects specific to this treatment model (5 questions). Each interview began with a brief introduction, after which participants were asked open-ended questions tailored to elicit detailed responses. When necessary, follow-up or clarifying questions were used to ensure participants addressed the core of each topic. In addition to the interviews, sociodemographic and diagnostic data were retrieved from the *HiX* database of Ziekenhuis Aan de Stroom (ZAS). These data provided the context of our study populations. To ensure the effectiveness of the interview design, a pilot study was conducted with one participant to evaluate whether the questions successfully elicited the intended responses and could be completed within the estimated time frame. Feedback from this pilot, which was not included in the analysis, informed minor refinements to the interview guide to ensure its suitability. Ethical standards were rigorously upheld throughout the research process. Interviews were conducted in a manner sensitive to the participants' mental health conditions, allowing participants to pause or terminate the session at any time to prioritize their well-being. This thoughtful and flexible approach ensured that data collection was ethically sound and methodologically robust.

Data analysis – The analysis followed a systematic thematic analysis approach using *MAXQDA24* software. Thematic analysis was considered most suitable for exploring the patterns within the dataset and addressing the research question. This method's flexibility allows for inductive (data-driven) exploration, facilitating a nuanced understanding of ET in psychotherapy among adolescents and young adults with severe mental health illnesses. This inductive approach prioritized participants' experiences and avoided pre-imposing analytical frameworks, ensuring the findings emerged directly from the data. Analysis was conducted using Braun and Clarke's six-phase framework, emphasizing accuracy and consistency in qualitative data exploration (Supplementary Table S2). This repeated and

participatory process enabled the identification of key patterns in the data, revealing both unique and shared aspects of ET as experienced by adolescents in therapy. The method facilitated an exploration of social and psychological interpretations, offering insights into the broader implications for clinical practice [26]. The first, second, and last authors collaboratively coded the transcripts to ensure consistency and validity, with regular team consultations to refine the coding framework.

Ethics considerations – This study adheres to the principles outlined in the Declaration of Helsinki (October 2013). Compliance with Belgian legal requirements was maintained, including the Law on Human Experiments (May 7, 2004), the Law on Clinical Trials (2017), and the General Data Protection Regulation (GDPR, May 25, 2016). Adherence to the Law on Patient Rights (February 6, 2024) and other applicable regulations was also ensured.

Ethical approval for the study was obtained from the ZNA Medical Ethics Committee of ZAS. Fully informed written consent was acquired from all participants before participation. Confidentiality was ensured through pseudonymization, removing identifiable information, and employing GDPR-compliant data handling procedures.

RESULTS

Participants – The clinical sample consisted of 12 adolescents and young adults (50% female, 50% male) aged between 18 and 24 years (mean=20.92, SD=1.83). Participants were engaged in therapy within the MPT 15 24 for durations ranging from 5 to 28 months (mean=23.17, SD=9.08). Participants were selected based on their experience of significant psychological distress associated with severe psychiatric and psychological illnesses. Most individuals presented with complex clinical profiles, often involving multiple disorders, such as schizophrenia spectrum and other psychotic disorders, bipolar and related disorders, depressive disorders, trauma- and stress-related disorders, substance-related and addictive disorders, feeding and eating disorders, neurodevelopmental disorders, and personality disorders. Regarding educational level, 25.0% had completed the first degree, 8.3% had discontinued their studies after the second degree, and 66.7% had completed the third degree of secondary education. All participants were born in Belgium and spoke Flemish. While raised in Belgium, they presented diverse ethnic backgrounds, including Belgian, Dutch, Moroccan, South American, and Jewish roots. Most participants lived at home at the time of the interview, except for one individual who lived independently. While a third of the participants were not receiving additional professional support during their engagement with the MPT 15 24, 91.67% had prior experiences with mental health services.

Themes – Our analysis produced five main themes of semi-structured interviews related to epistemic trust: 1) Therapist's basic attitude; 2) Therapist's voice as a guide; 3) Therapy as a safe space; 4) Recognition as a unique individual; and 5) Rupture and repair in the therapeutic relationship. Codes retrieved from the interviews using thematic analysis are presented in figures 1-5, each corresponding to one of the five themes.

Theme 1: Therapist's basic attitude. This theme highlights the therapist's basic attitude as a critical foundation for fostering ET in adolescents and young adults (Figure 1). Participants emphasized that an attuned, engaged, and non-judgmental attitude was essential to the development of ET. When therapists actively listened, demonstrated genuine interest, and acknowledged/validated participants' emotions, participants reported feeling more understood, reassured, and at ease. These interactions contributed to feeling supported and fostered a sense of safety within the therapeutic relationship.

Participants described how therapists' ability to pick up on and respond to their emotional states could guide the direction of therapy. This attunement created space for a more personalized therapeutic process. Furthermore, participants noted that non-verbal expressions, such as smiling or an enthusiastic demeanor, helped them feel more at ease and trust the therapist.

A participant noted: *"Listening. But also, you know, when you come to a psychologist, listening is kind of their job. But when they listen and then follow up on it the next day, that makes me feel like, 'Oh, they actually care about me.' Or, like, realizing that I'm not doing well and then involving more people to help."*

A non-judgmental and open attitude makes participants feel safe to express themselves fully. Many indicated that they did not feel pressured but understood and taken seriously. This fostered ET and the belief that their individual needs were acknowledged, with the therapists collaboratively seeking solutions tailored to them. Participants appreciated when they sensed that therapists were keeping them "in mind," as this communicated attentiveness, reduced feelings of pressure, and allowed the pace of therapy to align with their readiness. This approach also helped preserve hope and made room for small, attainable goals.

One participant illustrated this by saying: *"Yeah, it doesn't happen a lot, but it's just... the feeling that, if I need to, I can always ask for something or get something off my chest; that's reassuring."*

Ostensive cues, such as warmth, a warm greeting upon arrival, empathy, or the therapist's ability to remember previously shared information, were particularly valued. These gestures signaled genuine engagement, which, in turn, helped participants feel calm, welcomed, and correctly understood. Participants reported that these aspects contributed to feeling judged fairly and constructively, reinforcing their trust in the therapist and willingness to continue therapy.

As one participant described: *"Uh, no, I don't think so. It's mostly about how they do it. It's always just warm and open and everything. It's not that they say specific things that make me feel good. It's more the way they act."*

Theme 2: Therapist's voice as a guide. Participants describe the therapist's verbal contributions, such as asking questions, offering reflections, providing explanations or psychoeducation, giving feedback, offering compliments, and delivering positive confrontations, as essential guiding tools in therapy (Figure 2). These interventions helped participants develop a more positive (self-) image, recognize entrenched thought patterns, and gain insight into thinking errors. In several cases, psychoeducation and other clarification offered participants concrete strategies they could apply independently, contributing to a sense of progress and strengthening the therapeutic relationship. Participants frequently reported feeling supported, understood, and motivated to move forward.

As expressed by one of the participants: *"I was just talking about my relationship with my parents and how I think I'm disappointing them and stuff. And then the therapist said something like, 'But why do you think you're disappointing your parents?' And I said, 'Actually, I don't know.' And then they said, 'But you're doing so*

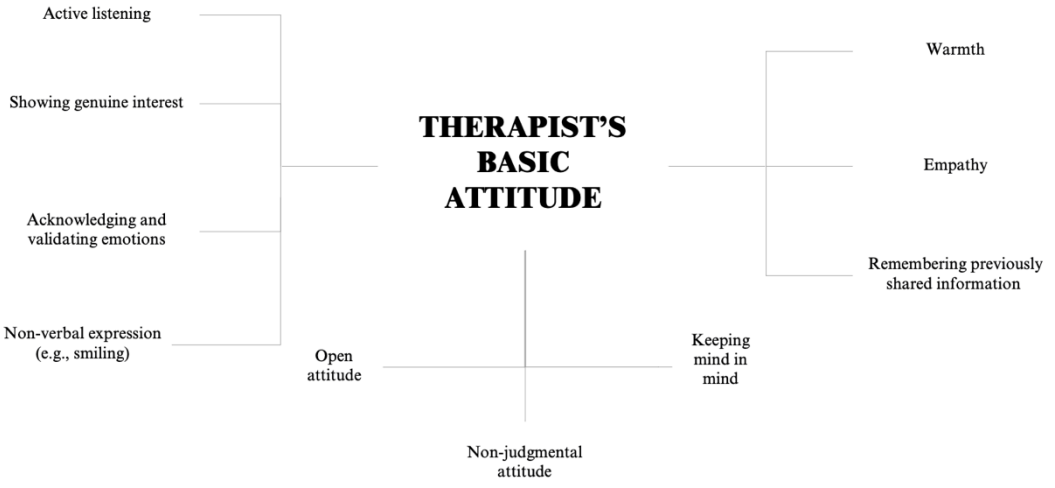

Figure 1. Theme 1: Therapist's basic attitude. Mind map of codes retrieved from 12 semi-structured interviews, illustrating theme 1: Therapist's basic attitude. Thematic analysis was conducted using Braun and Clarke's method to identify key codes and themes.

much and achieving so much in your life, why would you think that?' So they basically rephrased it, and then I automatically started thinking, 'Oh, maybe it's not how it seems in my head.'"

Therapists who were transparent by sharing their thought processes, offering clear feedback, and giving tailored advice fostered ET and engagement. Participants noted that this transparency provided direction and increased motivation. They described being more likely to try new things when therapists offered feedback or advice that felt attuned to their personal context. This kind of guidance also encouraged participants to broaden their thinking and support their desire to improve.

As one participant described: *"Yeah, I had a bad week, and I kind of dumped everything on the therapist. Then they said, 'Okay, stress—got it,' and then they gave me advice like, 'It's not the end of the world.' And I can just take that with me. It's like, okay, it's my day off or something. Then my whole day is made. I go to the gym, I can work out well, I can rest properly, I can game without getting annoyed. So yeah, I carry that with me."*

Several participants also emphasized the value of therapists paraphrasing their words or putting situations into perspective. These interventions brought relief and calm, helping participants feel reassured. They were more willing to trust the therapist and follow their guidance.

As shared in one participant's experiences: *"The therapist helps me see situations clearly. I tend to panic and lose sight of reality; like, I go straight to 'what if' thoughts. And then they help me go back to, 'What's actually happening right now? What's the actual what if'?"*

Theme 3: Therapy as a safe space. The perceived professionalism of the therapist strengthened ET in therapy (Figure 3). Participants acknowledged that the therapist's training and expertise reinforced their ET in treatment and increased their willingness to follow recommendations. The therapist's knowledge of relevant (cultural) factors and the therapeutic environment made participants feel understood and hopeful about the future. At the same time, therapists' human qualities were essential in creating comfort.

As shared in one participant's experiences: *"I am open to help. It would be stupid if they would say something, a person I do respect, but if they would say, Ah yes, okay, it was a busy week; try to take things a bit more calmly. [...] That I would say, 'Pfff, I'm not going to listen. What the fuck? Where do they want to tackle this? [...] That would be very stupid because I think they can estimate better than I can how it is. Because*

Figure 2. Theme 2: Therapist's voice as a guide. Mind map of codes retrieved from 12 semi-structured interviews, illustrating theme 2: Therapist's voice as a guide. Thematic analysis was conducted using Braun and Clarke's method to identify key codes and themes.

I can say it's bad and it's not going well. But then I still do many things, but whether that's good for me, I don't know. So I think they will know better than I do because the therapist is a professional. That's like going to a doctor, and I have to get cough spray, and I don't take cough spray because I don't need it. That's exactly that."

Participants also noted that involving multiple individuals in their care enhanced their ET. The presence of a team provided diverse perspectives and demonstrated that others were invested in their progress, which reinforced the feeling of being understood. The option to change therapists was important, as it offered participants a sense of being recognized and supported. This sense of connection with individual therapists and the broader team was central to their experience of safety and trust within therapy.

One participant illustrated this by saying: *"I think it's good that there's a team [...], but in a team, you can always think of things the other person doesn't think of or have a different insight. And yes, the therapist will certainly have things they want to inform or ask about what is best to do or if they didn't know how to interpret something or so. So yes, I think it's good there is a team…"*

Participants indicated that therapy provided a safe and supportive environment where they could be more open and share their needs. This contributed to feelings of relief and hope. They described being able to communicate more freely and to feel understood by their therapists. Importantly, participants experienced no pressure during sessions and appreciated the ability to proceed at their own pace. This environment fostered trust and encouraged them to ask questions, reinforcing the image of therapy as a safe space for open dialogue.

As expressed by one of the participants: *"I've had a feeling before with therapists who didn't listen but also didn't give me a good feeling. It's not about not listening; it's just all so direct, and it's all fast. It was all like, 'What are your problems?' and I didn't feel comfortable there. I also didn't share very much, but here I get a good feeling. I have more breathing space to share more. Instead of an annoying feeling of, I actually have to be here. I have to do this; I have to do that. I think over time I trusted more because of the things I've learned; they actually do that. Yeah, I don't know how to explain that. I've experienced before the feeling that I'm not comfortable with a therapist. Here, that's not the case. So that's pretty good."*

The freedom to make choices within therapy was seen as a source of hope and greater confidence. Participants felt empowered to try new approaches, apply therapeutic advice, and maintain a sense of agency over their treatment, which promoted their engagement without feeling pressured. Some expressed a desire to take more control in therapy, as this would allow them to share more openly. They also emphasized the value of positivity and variety in therapy topics, contributing to a pleasant experience and motivating them to continue participating.

One participant illustrated this by saying: *"The trust that I get. Because they really live alongside me. And it's not just someone who stands above me saying, okay, do this, do that, and... really the trust that I get, because of which I also feel this is advice that I can choose myself whether I want it or not, it's not an obligation, it's not my homework, so I think that already creates the feeling that I can be at my own pace, and that, in turn, increases that trust again. Because you are recognized as a person again, and you are respected for your pace."*

Theme 4: Recognition as a unique individual. Participants reported that ET developed when they felt recognized for their unique identity, regardless of their diagnosis or current problems (Figure 4). Being heard and seen as an individual provided relief and fostered the feeling that therapists were helping them as a person, not merely as a patient. This contributed to strengthening the therapeutic relationship and enabled further therapeutic progress. Participants described how this recognition helped them feel understood, as if the therapist could "see into their mind," which encouraged them to try new things and share more openly. This sense of recognition also provided a feeling of space. Participants felt they had the time to be themselves without pressure. It clarified their current situation, made them feel appreciated, and gave them hope and a sense of prospects. Some noted that

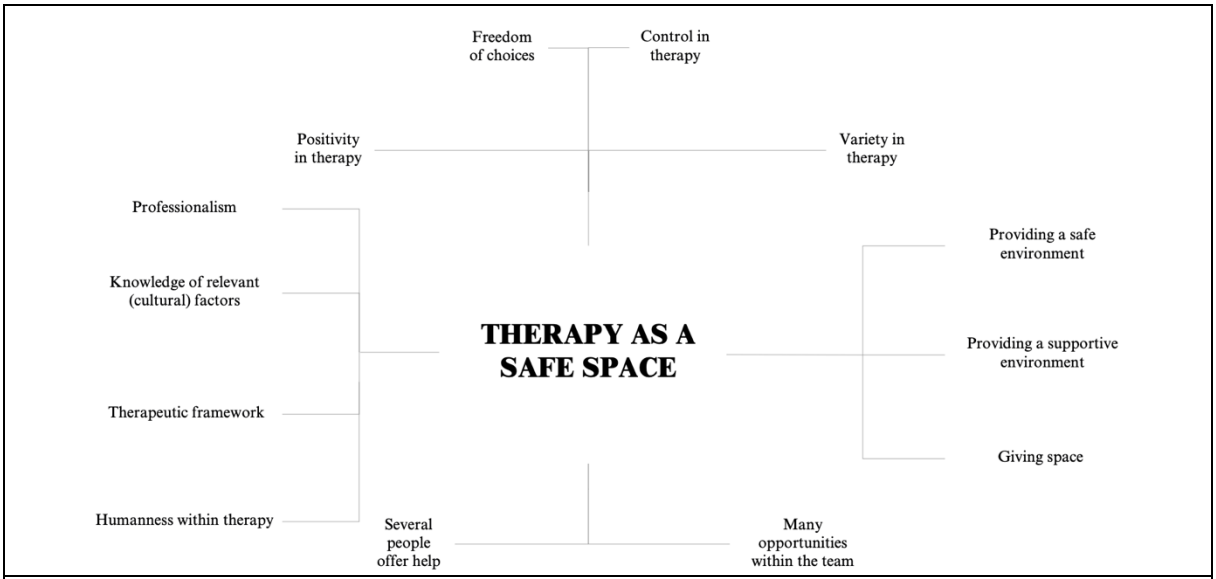

Figure 3. Theme 3: Therapy as a safe space. Mind map of codes retrieved from 12 semi-structured interviews, illustrating theme 3: Therapy as a safe space. Thematic analysis was conducted using Braun and Clarke's method to identify key codes and themes.

feeling listened to, respected, and understood increased their self-confidence and sometimes gave them energy and motivation to engage in therapy. Several participants emphasized that when therapists accurately observed or responded to their emotions, their trust was strengthened, and the positive effect of treatment extended into their daily lives.

One participant described this as: *"Mainly when I really felt like I was heard as a person and not just as a patient, let's say. That I really was able to be heard as a person and that I am respected as a person. That really gives me that good feeling that just gives me energy to be able to start the rest of the day."*

Participants also reported that when therapy was attuned to their emotional state and individualized, such as through shared humor, it enhanced their comfort and safety. This alignment increased their ET, facilitated greater openness, and encouraged them to participate more. Being seen alongside the therapist, both physically and mentally, enhanced their motivation to continue therapy and follow therapeutic advice.

One participant described this as follows: *"That they not just read from some kind of script on what to do. That they not read like, 'This is the answer to this question.' That they actually think for themselves, like, maybe this will help you; here's an idea. That it's not all just some kind of..."*

Additionally, they highlighted the importance of recognizing their illness and its consequences. This shared reflection on their condition's impact contributed to ET's development and supported collaborative problem-solving. The absence of pressure, along with receiving recognition and appreciation, allows them to internalize the benefits of therapy beyond the sessions themselves. Several expressed that feeling seen and understood, as who they are, confirmed the relevance of treatment in their personal development.

Theme 5: Rupture and repair in the therapeutic relationship. Participants described the therapeutic relationship as a dynamic process marked by feeling connected with the therapist and moments of tension or conflict (Figure 5). Their ruptures often arose when key relational foundations, such as understanding or equality, were perceived as lacking. Several young people noted that trust could be compromised when therapists were too direct, particularly when addressing sensitive topics or asking confronting questions. Such interactions were often experienced as overwhelming or misaligned, affecting ET.

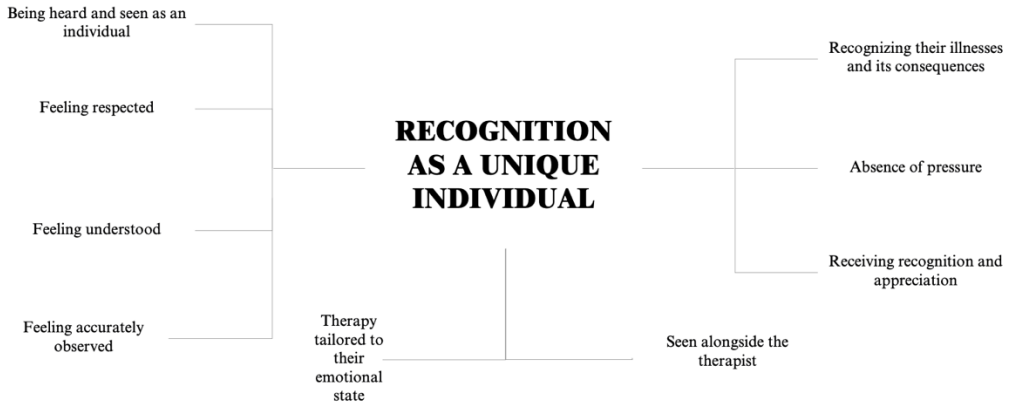

Figure 4. Theme 4: Recognition as a unique individual. Mind map of codes retrieved from 12 semi-structured interviews, illustrating theme 4: Recognition as a unique individual. Thematic analysis was conducted using Braun and Clarke's method to identify key codes and themes.

Feeling misunderstood, inaccurately judged, or not listened to caused some participants to withdraw, change the subject, or become less open. Therapists' expressions of irritation or impatience could make them feel like a burden, triggering disengagement or emotional shutdown. Participants mentioned feeling depersonalized or reduced to a diagnosis when the therapist's interpretations of their symptoms conflicted with their understanding. Vague advice, perceived lack of confidentiality, or assumptions about their experiences were further cited as moments when trust was disrupted. Some responded by seeking answers online or disengaging from therapy.

As one participant put it: *I don't feel heard, so I can't take it seriously to say things like that. If they say their advice or something, I can't take it seriously. Because you don't listen to me, but you tell me what to do. That's kind of weird, but... So yeah."*

Ruptures were also linked to the dynamics within sessions. Participants described feeling uncomfortable and having limited space to speak freely when the silence became awkward or when they felt overly analyzed. A harsh tone or distracted body language made some feel diminished or unequal, like a "project" rather than a person. Others recalled feeling intimidated when therapists seemed judgmental. Practical missteps (e.g., forgetting topics from previous conversations or missing appointments) indicated a lack of care or attention.

As one participant said: *" [...] I said, no, that doesn't work for me; it's a whole hassle. And they said: 'Come on, be normal.' 'Be normal' is a very harsh thing to say. At that time, I knew about myself that I wasn't 'normal.' Now I'm okay with that. But back then, when people said that, it was very sensitive. That really hit me."*

One participant said: *"...But with those people, if I'm sure of those are analyzing me now [...] I do really not like that."*

In several cases, participants reported that their emotions were minimized, or they felt accused, which reduced openness. Once belief in the therapist's competence or intentions eroded, participants described struggling to take in guidance or feeling detached. Feelings of guilt or discomfort also emerged when the therapist applied pressure or made inappropriate remarks.

While such moments felt like a breach of trust, participants emphasized they were not necessarily irreparable. Many participants stressed that trust could be restored. Repair became possible when the therapist acknowledged their mistakes, offered

apologies, and demonstrated an openness to feedback. Acts of repair included asking what could be done differently, adjusting the therapeutic approach based on participants' input, or admitting when something was not fully understood. Such gestures helped participants feel respected, validated, and more willing to re-engage.

One participant described it: *"A 'sorry' would make sense of 'Sorry, we didn't understand you, we didn't see how that was for you."*

Another participant: *"They listen, and then they also agree reasonably with what I said. That helps, of course. And then just explain where the problem was. That you understood it as well."*

Ongoing contact, especially after periods of disengagement, was often seen as meaningful and trust-enhancing. Participants appreciated when therapists continued to reach out, reinforcing the sense of a reliable and committed relationship. Some participants stated they understood that therapists could make mistakes, which softened the impact of ruptures and preserved a foundation of trust.

Elements from earlier themes also facilitated repair. Demonstrating interest, offering space for dialogue, being transparent (e.g., about intentions), and clarifying decisions during disagreements were all cited as helpful. Participants reported feeling more understood and supported when the therapist adopted a collaborative attitude in verbal communication and expression. This led to fewer cancellations, more openness, and stronger therapeutic relationships. Providing time for the patient to reflect, after a rupture, also allowed participants to process the experience and eventually re-engage with therapy.

DISCUSSION

Our study aimed to explore how ET is built, challenged, and restored within the therapeutic relationships between adolescents and young adults and their caregivers in the MPT 15 24. Through semi-structured interviews involving 12 participants with severe psychiatric and psychological illnesses and using thematic analysis, we identified five overarching themes that reveal how ET evolves within this context. Each theme highlights key factors contributing to ET's building, including challenges and restoration.

The first theme highlights the underlying role of the therapist's basic attitude in fostering ET. Participants emphasized that when therapists adopted an attuned, open, non-judgmental, and warm attitude, they felt more understood, supported, and safe within the therapeutic relationship. This basic attitude, characterized by engagement, emotional attunement, and a non-pressuring presence, allowed participants to feel seen and acknowledged as individuals. The second

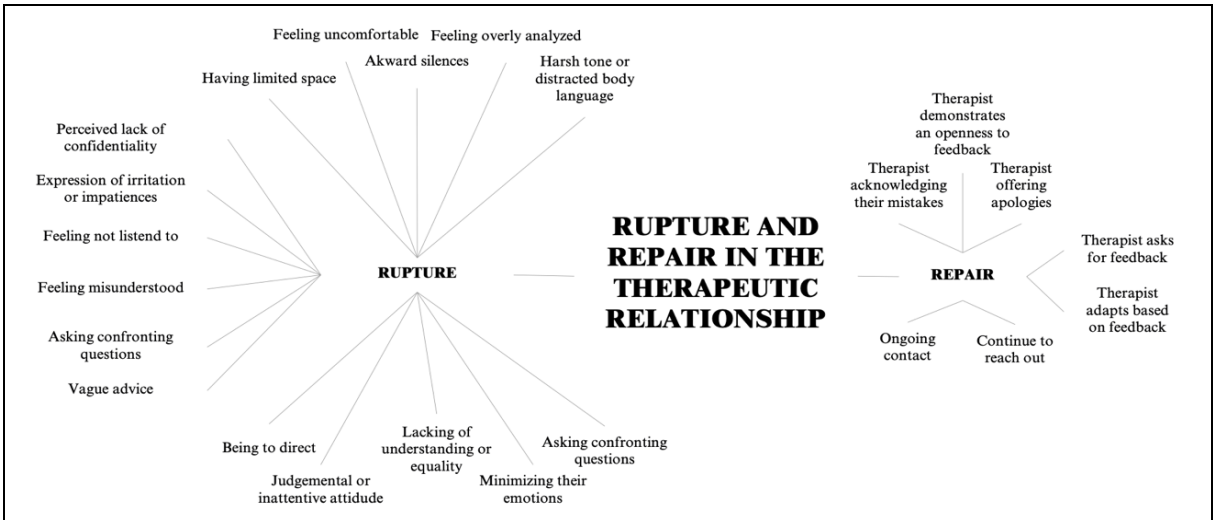

Figure 5. Theme 5: Rupture and repair in the therapeutic relationship. Mind map of codes retrieved from semi-structured interviews, illustrating theme 5: Rupture and repair in the therapeutic relationship. Thematic analysis was conducted using Braun and Clarke's method to identify key codes and themes.

theme emphasized the importance of the therapist's voice in fostering ET. Verbal interventions such as asking questions, offering reflections, providing psychoeducation, giving feedback, and tailoring advice helped participants gain insight into their thoughts and behaviors. These contributions supported (self) understanding and conveyed a sense of being understood and supported, which deepened the therapeutic relationship. Transparent communication and attuned guidance motivated participants to apply therapeutic strategies. In theme three, therapy was described as a safe space. This sense of safety was fostered through the therapist's professional expertise, human qualities, and the team's collaboration. Participants reported feeling supported and understood by their therapist. ET was further strengthened by the absence of pressure and the opportunity to make choices within therapy. These elements promoted a sense of agency, ensured open communication, and encouraged them to try new things. The value of being recognized as an individual was highlighted in theme four. ET was strengthened when therapists saw them as persons rather than diagnostic cases. Feeling understood encouraged openness and motivation to engage in therapy. Recognition of individual needs and emotional states contributed to a sense of safety, helped participants feel understood, and enabled therapeutic progress. The final theme underscored the dual importance of rupture and repair in therapy. ET and the therapeutic relationship were sometimes challenged during moments of tension, misunderstanding, or perceived inequality. Such ruptures could lead to withdrawal or EC, particularly when participants felt unheard or confronted too directly. However, ET and the relationship could be restored when therapists acknowledged missteps, offered apologies, or sought feedback. These repair attempts were often experienced as validating and helped participants to re-engage in therapy. Moreover, therapists who remained available and continued to reach out during difficult moments demonstrated a commitment that strengthened the therapeutic relationship and reestablished ET.

The five themes from this study align closely with existing theoretical frameworks on ET, particularly the theory of the three communication systems proposed by Fonagy *et al.* (2015, 2017, 2019) as a mechanism for resolving EM and fostering ET in psychotherapy [8-11]. These systems outline a sequential, repeated process of therapeutic engagement [8]. Our findings suggest that the key elements of each system were reflected in multiple themes.

System 1 involves the therapist using ostensive cues and communicative signals to establish an epistemic match. This signals to the patients that the therapist is a trustworthy and relevant source of knowledge, thereby establishing epistemic openness [8-11]. In theme 1, which highlights the significance of the therapist's basic attitude, participants emphasized the importance of non-verbal and verbal signals that conveyed attunement and genuine interest, such as warmth, empathy, active listening, and a non-judgmental attitude. These cues helped foster safety and engagement, building an epistemic match. Additionally, several factors appeared to reinforce the epistemic match. Participants appreciated when therapists appeared to "keep them in mind," which was perceived as a collaborative search for understanding (theme 1). Similarly, theme 4 (feeling seen as a unique individual) also resonated with system 1. When participants felt genuinely recognized and heard, the epistemic match was reinforced. Interestingly, theme 5 underscored the fragility of this match, showing how ruptures, such as feeling misunderstood, could disrupt ET. However, participants described how these breaks could be repaired when therapists acknowledged misunderstandings and offered alternative perspectives. Such repairs not only reestablished ET but could also improve it.

System 2 describes a shift wherein patients view the therapist as a credible source of knowledge, enabling them to enter a learning relationship and expand their mentalizing capacities, thereby creating the "we-mode" [8-11]. This dynamic was reflected in themes 2 and 3. Participants described how therapists' verbal interventions, such as feedback, psychoeducation, tailored advice, and offering new perspectives, enabled them to question assumptions, revise thought patterns, and better understand themselves (theme 2). Moreover, the perceived expertise of the therapist contributed to the establishment of ET (theme 3). Participants expressed that the therapist's professional knowledge, expertise, and ability to contextualize problems, e.g., within cultural frameworks, made them feel understood and

more likely to accept advice. Another important aspect was the collaborative, team-based approach of the MPT 15 24. Participants felt that the involvement of multiple team members provided additional perspectives and reinforced a shared investment in their well-being. This further enhanced their trust and facilitated the integration of new insights. Theme 5 again intersected with this system, as repair processes often involved therapists offering their perspective to help participants feel heard and to create the "we-mode".

System 3 involves generalizing the therapeutic gains to other social relationships, allowing patients to apply new perspectives [8-11]. While this system was less discussed in the interviews, some evidence for its relevance emerged, particularly within theme 4. Participants described how being accurately seen and emotionally validated by their therapist positively influenced their functioning outside therapy. However, further research is needed to explore this process in more depth.

Although the systems are theoretically presented sequentially, Fonagy *et al.* (2015, 2017, 2019) emphasize their dynamic and overlapping nature [8-11]. Our findings support this view. Themes often reflected mechanisms from multiple systems, illustrating that these processes are not strictly linear. Further research should continue to investigate these interrelations.

Additionally, our findings are supported by existing literature. First, our finding that a therapist's basic attitude fosters the development of ET is aligned with what Nolte *et al.* (2023) describe as the activation of the "we-mode" in MBT. According to Nolte, we-mode reflects a form of social cognition that arises through joint attention and co-mentalizing, whereby therapist and patient collaboratively explore internal states. This shared mental focus enables a reappraisal of experiences as an essential mechanism through which psychotherapy exerts change [12]. In our data, participants repeatedly emphasized how feeling seen "in the same way" by their therapist allowed them to feel understood and become more open to the therapist. This was especially evident in themes 1 and 4, where the search for an epistemic match (system 1), feeling mirrored and accurately understood, emerged as central to building ET. Nolte *et al.* further argue that the therapists' ability to recognize and respond to what is meaningful and personally relevant to the patient is critical in establishing ET [12]. Our participants echoed this in themes 1 and 4. Moreover, consistent with the MBT principle of the "not knowing attitude," our participants valued a therapist who remained curious, open, and collaborative rather than being directive (theme 1). In theme 2, participants also mentioned they find it helpful when therapists provide psychoeducation or tailored feedback. This was also emphasized as necessary in the research of Nolte *et al.*, as it would offer a frame for patients to attach their own experiences and to make better sense of themselves in the future [12]. These results of Nolte *et al.* were apparent across our themes. In line with this, several other studies emphasized the importance of adapting therapeutic interventions to adolescents' developmental needs rather than adhering to therapeutic models [8, 27, 28].

The role of rupture and repair (theme 5) is another key point of convergence with the literature. Haskayne *et al.* (2024) underscore how ruptures often occur when patients feel emotionally vulnerable or perceive a lack of attunement [29]. These observations were echoed by our participants, who described moments of epistemic disruption when they felt unheard or confronted. However, Haskayne *et al.* emphasize that these ruptures, when acknowledged and repaired, can deepen the therapeutic relationship [29]. Our participants confirmed this as they said that therapists who apologized, sought feedback, or remained available during difficult moments could foster ET. Folmo *et al.* (2019) found that highly rated therapists could tolerate patients' negative affect and challenge them without abandoning the therapeutic relationship. In our study, this capacity was reflected in participants' appreciation for therapists who could identify and explore their thoughts while maintaining a sense of mutual respect and commitment (themes 2, 4, and 5) (system 2) [23]. Finally, Palepu *et al.* (2023) emphasized that the development of ET rests on three core conditions: interpersonal trust, client self-agency, and the therapist's intrapersonal ET [30]. Our participants likewise described how ET was developed over time through repeated experiences of being understood, respected, and supported in emotionally meaningful ways (themes 1-4). Palepu *et al.* also identified therapist authenticity and positive regard as central to ET [30]. These findings were mirrored in our participant's emphasis on the

therapist's humanness and warmth (themes 1 and 5). This is a part of ostensive cueing, which plays a role in system 1. Fonagy *et al.* (2019) highlighted the importance of ostensive cues, where patients mentioned feeling understood by their therapist through mentalization as necessary in therapy. It ensured that the information was personally relevant to the patient and, therefore, worth internalizing and believing [9, 30]. Our findings are in line with the work of Li *et al.* (2022), who emphasize that an interpersonal component within or beyond therapy may be critical in shifting adolescents from a state of EM to ET [6]. In themes 1, 3, and 5, participants stressed the importance of a therapist's basic attitude, expertise, and consistent availability in fostering ET. Li *et al.* similarly conclude that therapist behaviors characterized by empathy and expertise contribute to a strong therapeutic relationship, which breaks the cycle of EM and supports recovery in depressed adolescents [6]. Our findings also resonate with those reported by Li *et al.* (2025), who conducted additional research into how EM is resolved and how ET develops within therapy. Their results aligned with and extended the theoretical framework of the three communication systems [8-11]. They found that therapists are perceived as trusted sources of relevant insight. Therapists are essential in fostering epistemic openness and establishing an epistemic match within system 1, a finding we also identified across themes 2 and 3 [8]. Moreover, their study emphasized that agreement on therapeutic tasks and goals represented a key pathway to achieving this match, echoing the propositions of Bordin (1979). They identified two mechanisms that promote this match: the demonstration of how the therapeutic model helps make sense of the specific difficulties and the experience of having one's subjective perspective acknowledged and validated [8, 31]. These two components were mirrored in our findings, particularly in themes 2, 3, and 4, highlighting their role in ET development within the therapeutic relationship. Li *et al.* (2025) further noted that resolving EM is not solely reliant on the therapist's interventions or the essential elements of the therapy. The interactive nature of the therapeutic process, which means that patient involvement is critical, also plays a role. They suggest therapist responsiveness, such as adapting to the patient's needs, can foster a more collaborative therapeutic environment [8]. Our findings support this within themes 4 and 5. We observed that seeing the patients as individuals and listening to them during the rupture and repair moments often helped enhance the therapeutic relationships.

Taken together, our study contributes meaningful and new insights to the literature of ET. Through thematic analysis of the perspectives of a heterogeneous group of adolescents and young adults facing severe psychiatric illnesses, we demonstrated additional elements of how ET can be built, challenged, and repaired through therapeutic interactions. Importantly, our findings underscore the value of the theory of the three communication systems as a guiding framework [8-11]. What distinguishes our study is its demonstration of patterns of ET development from the perspective of a complex and vulnerable heterogeneous clinical population. While much of the existing literature has focused on specific diagnoses or treatment settings, our findings suggest that mechanisms for developing ET apply across a broad range of clinical presentations. This observation adds a crucial dimension to current research. It indicates that, regardless of specific diagnosis, therapeutic interventions based on the principles of the communication systems can promote ET in adolescents with complex and comorbid mental health illnesses. This added value is especially relevant given the common prevalence of comorbidity in real-world clinical populations [32].

Strengths and limitations – By analyzing qualitative interview data from adolescents with severe mental health illnesses using thematic analysis, this study provides valuable insights into key patterns of ET, highlighting both shared and unique experiences of ET within therapeutic contexts. To the best of our knowledge, this is the first study to explore ET from the perspective of a complex and vulnerable clinical population. Since all identified themes emerged among all our participants, regardless of their diagnostic profile, this suggests the presence of shared processes, which may support the generalizability of our findings to other clinical groups. Furthermore, the interview was specifically adapted to align closely with our research question, enhancing the depth and relevance of the data collected.

However, several limitations must be acknowledged. Given our relatively small

sample size (n=12), we could not conclude potential differences in ET experiences across the different diagnostic groups. Nevertheless, thematic saturation was achieved, and no new themes emerged in the later interviews, suggesting that additional interviews were unlikely to yield novel insights for this research. Additionally, due to practical constraints during the data collection period (e.g., participant availability), all participants included in the study were over the age of 18. Given the average age of the caseload (Mean=20.49), older participants were more likely to be accessible, limiting the inclusion of minors in the sample. This means our sample does not fully represent the broader age range of the MPT 15 24 caseload. Another limitation is that all participants were still in therapy during the interviews. As a result, we could not examine the dynamics of ruptures that may have led to disengagement from treatment or how such ruptures affect ET. Moreover, the limited interviewing experience of the first author, who conducted the semi-structured interviews, may have resulted in missed follow-up questions that could deepen the insights gained. However, the interviewer received prior training from the second author, a psychologist. Additionally, the study's retrospective nature, which relied on participants' recollections of past therapeutic experiences, may have introduced recall bias or subjective distortions. Nevertheless, the narratives shared reflect their lived perspectives and the memories they retained, which remain valuable and meaningful for understanding ET. We hope future studies will build on these insights and address the limitations.

Future research – This study primarily focused on the first two communication systems related to ET, offering insights into how ET is established and supported within the therapeutic context. For instance, participants described the importance of feeling seen and heard, experiencing an epistemic match, and being recognized as autonomous agents as key indicators of communication system 1. Similarly, therapists' displays of curiosity and efforts to foster a shared understanding ("we-mode") contributed to the restoration of mentalizing capacity, reflecting communication system 2 [9]. However, our findings revealed a significant gap regarding communication system 3, which is the capacity for patients to engage in ET and social learning beyond the therapeutic setting [9]. Future research should explore how therapeutic work can support patients in generalizing ET to broader social contexts, enabling sustained interpersonal growth outside of therapy.

Additionally, future studies should address the phenomenon of ruptures in therapy that remain unresolved. Our sample included only participants who continued treatment, limiting our ability to explore the experiences and needs of individuals who dropped out due to EM. Research focusing on this particularly vulnerable group, those who withdraw from therapy, could provide essential insights for developing interventions tailored to prevent or repair ruptures that otherwise remain unrepaired.

This study focused solely on the patient's perspectives regarding the development of ET in therapy, thereby capturing only one side of the therapeutic relationship. Future research should consider including therapists' viewpoints to provide a more comprehensive understanding of how ET evolves.

Future research could build on the results by using a larger sample size to explore the potential differences in how ET develops within a complex and vulnerable clinical population. While this study focused on themes across a heterogeneous clinical population, examining within the group variations could yield more insights into the mechanisms underlying ET in distinct diagnostic profiles.

Longitudinal research would also be valuable, as our study relied on a single interview per participant. Tracking changes in ET across different phases of the therapeutic process could offer a deeper understanding of how ET evolves over time and how it influences the therapeutic relationship, the therapeutic process, and outcomes. Such knowledge could better inform clinical practices, helping therapists to intentionally use the three communication systems to strengthen ET and enhance treatment effectiveness.

CONCLUSION

Using thematic analysis of twelve interviews with young adults and adolescents experiencing severe mental health illnesses, this study identified five themes that show how ET is built, challenged, and restored in psychotherapy. These findings extend the existing literature by providing preliminary evidence from the perspective of this specific population. We identified mechanisms similar

to those previously reported in specific clinical populations while uncovering additional insights. This suggests that our results may be applicable across a broader spectrum of mental health disorders. Notably, all themes were present across interviews, indicating that the development of ET is a shared therapeutic process in diverse clinical contexts. These findings highlight the clinical relevance of our results, suggesting practical strategies for therapists aiming to build, shape, and restore ET. First, adopting a basic therapeutic attitude characterized by warmth and empathy appears essential. Second, the therapist should demonstrate curiosity to explore the patient's perspective through questions and transparency. Third, providing a clear framework helps through the therapist's professionalism and the absence of pressure. Fourth, the therapist must recognize and respond to the patient as an individual, beyond diagnostic labels, acknowledging personal experiences and identity. Finally, identifying and repairing ruptures in the therapeutic relationship through apologies was considered necessary to restore ET. Adopting these psychotherapy strategies may enhance communication systems 1 and 2, which are central to developing ET, effective therapeutic relationships, and improving the therapeutic process. Further research should continue to focus on the development of ET across different contexts and perspectives, with attention to how it extends beyond therapeutic settings.

REFERENCES

1. Knapen S, van Diemen R, Hutsebaut J, Fonagy P, Beekman A. Defining the Concept and Clinical Features of Epistemic Trust: A Delphi study. J Nerv Ment Dis. 2022;210(4):312-4.
2. Sprecher EA, Elizabeth L, Michelle S, and Midgley N. 'Trust me, we can sort this out': a theory-testing case study of the role of epistemic trust in fostering relationships. Qualitative Research in Psychology. 2022;19(4):1117-42.
3. Riedl D, Rothmund MS, Grote V, Fischer MJ, Kampling H, Kruse J, et al. Mentalizing and epistemic trust as critical success factors in psychosomatic rehabilitation: results of a single center longitudinal observational study. Front Psychiatry. 2023;14:1150422.
4. Campbell C, Tanzer M, Saunders R, Booker T, Allison E, Li E, et al. Development and validation of a self-report measure of epistemic trust. PLoS One. 2021;16(4):e0250264.
5. Locati F, Benzi I, Milesi A, Campbell C, Midgley N, Fonagy P, et al. Associations of mentalization and epistemic trust with internalizing and externalizing problems in adolescence: A gender-sensitive structural equation modeling approach. Journal of Adolescence. 2023;95.
6. Li ET, Midgley N, Luyten P, Sprecher EA, Campbell C. Mapping the journey from epistemic mistrust in depressed adolescents receiving psychotherapy. J Couns Psychol. 2022;69(5):678-90.
7. Fonagy P, Allison E. The role of mentalizing and epistemic trust in the therapeutic relationship. Psychotherapy (Chic). 2014;51(3):372-80.
8. Li E, Midgley N, Campbell C, Luyten P. A theory-building case study of resolving epistemic mistrust and developing epistemic trust in psychotherapy with depressed adolescents. Psychother Res. 2025:1-19.
9. Fonagy P, Luyten P, Allison E, Campbell C. Mentalizing, Epistemic Trust and the Phenomenology of Psychotherapy. Psychopathology. 2019;52(2):94-103.
10. Fonagy P, Luyten P, Allison E. Epistemic Petrification and the Restoration of Epistemic Trust: A New Conceptualization of Borderline Personality Disorder and Its Psychosocial Treatment. J Pers Disord. 2015;29(5):575-609.
11. Fonagy P, Luyten P, Allison E, Campbell C. What we have changed our minds about: Part 2. Borderline personality disorder, epistemic trust and the developmental significance of social communication. Borderline Personal Disord Emot Dysregul. 2017;4:9.
12. Nolte T, Hutsebaut J, Sharp C, Campbell C, Fonagy P, Bateman A. The Role of Epistemic Trust in Mentalization-Based Treatment of Borderline Psychopathology. Journal of Personality Disorders. 2023;37(5):633-59.
13. Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustün TB. Age of onset of mental disorders: a review of recent literature. Curr Opin Psychiatry. 2007;20(4):359-64.

14. Aguirre Velasco A, Cruz ISS, Billings J, Jimenez M, Rowe S. What are the barriers, facilitators and interventions targeting help-seeking behaviours for common mental health problems in adolescents? A systematic review. BMC Psychiatry. 2020;20(1):293.
15. Keller TE, Cusick GR, Courtney ME. Approaching the Transition to Adulthood: Distinctive Profiles of Adolescents Aging out of the Child Welfare System. Soc Serv Rev. 2007;81(3):453-84.
16. Schlack R, Peerenboom N, Neuperdt L, Junker S, Beyer AK. The effects of mental health problems in childhood and adolescence in young adults: Results of the KiGGS cohort. J Health Monit. 2021;6(4):3-19.
17. Li E, Campbell C, Midgley N, Luyten P. Epistemic trust: a comprehensive review of empirical insights and implications for developmental psychopathology. Res Psychother. 2023;26(3).
18. Knapen S, Hutsebaut J, Diemen R, Beekman A. Epistemic Trust as a Psycho-marker for Outcome in Psychosocial Interventions. Journal of Infant, Child, and Adolescent Psychotherapy. 2020;19:1-10.
19. Riedl D, Kampling H, Kruse J, Nolte T, Labek K, Kirchhoff C, et al. Epistemic Trust Is a Critical Success Factor in Psychosomatic Rehabilitation-Results from a Naturalistic Multi-Center Observational Study. J Clin Med. 2023;13(1).
20. Silva M, Loureiro A, Cardoso G. Social determinants of mental health: A review of the evidence. The European Journal of Psychiatry. 2016;30(4):259-92.
21. Demetriou C, Özer B, Essau C. Self-Report Questionnaires. 2015.
22. Thomas N, and Jenkins H. The journey from epistemic vigilance to epistemic trust: service-users experiences of a community mentalization- based treatment programme for Anti-Social personality disorder (ASPD). The Journal of Forensic Psychiatry & Psychology. 2019;30(6):909-38.
23. Folmo E, Karterud S, Kongerslev MT, Kvarstein E, Stänicke E. Battles of the Comfort Zone: Modelling Therapeutic Strategy, Alliance, and Epistemic Trust—A Qualitative Study of Mentalization-Based Therapy for Borderline Personality Disorder. Journal of Contemporary Psychotherapy. 2019;49:141-51.
24. Jaffrani A, Sunley T, Midgley N. The Building of Epistemic Trust: An Adoptive Family's Experience of Mentalization-Based Therapy. Journal of Infant, Child, and Adolescent Psychotherapy. 2020;19:1-12.
25. Orenstein GA, Lewis L. Erikson's Stages of Psychosocial Development. StatPearls. Treasure Island (FL): StatPearls Publishing
Copyright © 2025, StatPearls Publishing LLC.; 2025.
26. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Research in Psychology. 2006;3(2):77-101.
27. Briggs S. Working with Adolescents and Young Adults: A Contemporary Psychodynamic Approach2008.
28. Verduyn P, Delvaux E, Van Coillie H, Tuerlinckx F, Van Mechelen I. Predicting the duration of emotional experience: two experience sampling studies. Emotion. 2009;9(1):83-91.
29. Haskayne D, Larkin M, Hirschfeld R. What are the Experiences of Therapeutic Rupture and Repair for Clients and Therapists within Long-Term Psychodynamic Therapy? British Journal of Psychotherapy. 2014;Britsh Journal of Psychotherapy:68-86.
30. Radhika Palepu GNH, Sharon Lawn & John Mcmillan. Epistemic Trust and its Utility in Psychotherapy. International Journal of Psychotherapy 2023;Vol. 27, No. 1:pp. 29-41:.
31. Bordin ES. The generalizability of the psychoanalytic concept of the working alliance. Psychotherapy: Theory, Research & Practice. 1979;16(3):252-60.
32. McGrath JJ, Lim CCW, Plana-Ripoll O, Holtz Y, Agerbo E, Momen NC, et al. Comorbidity within mental disorders: a comprehensive analysis based on 145 990 survey respondents from 27 countries. Epidemiol Psychiatr Sci. 2020;29:e153.

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SUPPLEMENTAL

Table S1. Inclusion and exclusion criteria for the participants with severe mental and psychiatric illnesses.

Inclusion Criteria	Exclusion Criteria
Adolescents and young adults with severe mental and psychiatric illnesses (e.g., depression, psychosis, autism, etc.).	Inability to clearly express interest in participation, e.g., due to a psychotic state.
Patients currently in treatment with MPT 15 24 or recently (within the past 3 months) completed their treatment.	Limited comprehension of the Dutch language, as assessed by the researchers or reported by the youth.
Aged between 15 and 24 years old.	Persons who completed their treatment trajectory more than 3 months ago.
Capable of completing a 90-minute interview	Illiteracy or aphasia.
Adolescents and/or legal representatives provided informed consent.	

MPT, Mobiel Psychiatrisch Team.

Table S2. Phases of thematic analysis according to Braun and Clark.

Step	Description
1. Familiarization with the data	The researcher reads and re-reads the data, taking initial notes on patterns and meanings.
2. Initial Coding	Systematically identify and label essential features of the data across the dataset.
3. Search for Themes	Group codes into potential themes and gather relevant data for each theme.
4. Refining Themes	Check if themes work with coded extracts and the entire dataset; refine if necessary.
5. Defining Themes	Refine the specifics of each theme and create clear names and definitions.
6. Reporting	Finalize the analysis, select compelling examples, and write a coherent, evidence-based report.

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