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Selective Epistemic Trust and the Recovery of Agency After Interpersonal Trauma

Prof. Dr. Melis Avci¹

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ABSTRACT

Interpersonal trauma can disturb how people evaluate communicated information, yet greater willingness to accept advice is an ambiguous marker of psychological recovery. A person may become more receptive to useful guidance while also becoming less able to question unreliable authority. This critical integrative review examines whether selective epistemic trust offers a more defensible clinical objective than increasing trust alone. Targeted searches of biomedical records, publisher resources, and relevant reference lists informed a synthesis of developmental theory, psychometric research, psychotherapy process studies, and scholarship on epistemic injustice. The evidence supports distinguishing trust, mistrust, and credulity, but associations with symptoms vary across instruments and populations. Recent behavioural and observational studies extend assessment beyond self-report, although they do not establish that increasing advice acceptance causes recovery after trauma. The article develops an evaluative framework connecting sensitivity to information quality with the patient's capacity to question, revise, and retain ownership of decisions. Its central proposition is that therapeutic benefit should include learning from credible communication without making agreement with the clinician the criterion of improvement. A proposed research programme separates source reliability, emotional safety, prior confidence, and the consequences of error; combines repeated behavioural assessment with session observation and patient-defined outcomes; and tests whether changes generalise beyond the treatment relationship. Competing explanations include symptom relief, alliance quality, task familiarity, and accommodation to authority. Selective trust remains a candidate process requiring prospective validation. Its immediate contribution is to clarify what successful social learning should preserve: openness to evidence together with meaningful authorship of personal choices.

Keywords: epistemic trust; interpersonal trauma; epistemic agency; therapeutic alliance; mentalization

Keywords: *Selective; Epistemic; Trust; Recovery; Agency.*

A patient can leave psychotherapy more willing to accept another person's interpretation while remaining uncertain whether disagreement is permitted. That possibility exposes a difficulty in defining recovery after interpersonal trauma. Supportive relationships can make unfamiliar perspectives usable, but willingness to agree does not reveal whether a person can judge their relevance, question their accuracy, or decline a proposed action. Clinical accounts of epistemic trust address the reception of socially communicated knowledge and its potential to reopen learning after adverse relationships (Fonagy & Allison, 2014). The question developed here concerns the quality of that reopening. If treatment increases receptivity, what would demonstrate that the patient has gained greater authority over decisions rather than become dependent on a more benevolent source of direction?

This question is particularly pertinent when harmful relationships have involved coercion, repeated invalidation, or dependence on an unreliable caregiver. Such experiences do not produce one uniform psychological response. Developmental accounts describe several routes from adversity to later difficulties, including changes in threat processing, emotion regulation, and social cognition (McLaughlin et al., 2020). Epistemic approaches add the possibility that information from others becomes persistently difficult to use, or is accepted without sufficient discrimination (Fonagy et al., 2017). These are propositions about vulnerability and adaptation, not grounds for assuming that every survivor is mistrustful or easily influenced. The same person may evaluate one source carefully, rely heavily on another, and withhold judgement in circumstances where caution is justified.

Research now permits a more precise discussion than was possible when epistemic trust was principally a theoretical construct. The Epistemic Trust, Mistrust and Credulity Questionnaire introduced separable dimensions of interpersonal information processing (Campbell et al., 2021).

et al., 2026; Li et al., 2026). These developments also complicate a simple equation between trust and health. Associations differ by measure, clinical setting, and level of analysis. A questionnaire about general openness, a rating of a therapy conversation, and behaviour after misleading advice are related observations, but they are not interchangeable measures of recovery.

The relationship itself must therefore be examined alongside the patient. A therapist can be experienced as warm and convincing while communicating an interpretation that is poorly supported or unsuitable for the patient's circumstances. Conversely, a patient may decline a recommendation for sound reasons without rejecting the therapeutic relationship. Work on epistemic injustice shows how clinical authority can reduce the credibility accorded to a patient's account (Carel & Kidd, 2014; Crichton et al., 2017). This concern becomes analytically important when treatment success is partly judged through receptivity to the clinician. An outcome definition that counts agreement as progress and disagreement as pathology could reproduce the very asymmetry it seeks to repair.

This article asks how adult psychotherapy after interpersonal trauma could evaluate social learning while preserving the patient's epistemic agency, understood here as the practical capacity to assess reasons and participate in decisions that concern one's own life. It proposes selective epistemic trust as a candidate process, meaning responsiveness to the quality and relevance of communication rather than a uniformly high level of acceptance. The contribution is a critical integration and a prospective research framework. Selective trust, adaptive caution, and patient participation already have substantial theoretical precedents; no claim of first discovery is made. The following sections distinguish what existing studies establish from what remains to be tested, then develop criteria through which the proposed framework could succeed or fail.

This is a critical integrative narrative review with a conceptual extension. It does not report a new clinical sample, a treatment trial, or a pooled effect estimate. The review question concerns whether current evidence can support evaluating information discrimination and decision ownership together in adult psychotherapy following interpersonal trauma. Relevant literature was organised into developmental accounts, assessment studies, treatment process research, and analyses of clinical authority. The emphasis is on the inferential connection between these areas, rather than estimating the prevalence of a condition. The review follows the emphasis on a clear question, described search, appropriate referencing, and scientific reasoning articulated in SANRA (Baethge et al., 2019).

Search and source selection

Targeted searches were conducted on 30 September 2026 using PubMed-indexed records accessed through Europe PMC, scholarly web searches, publisher pages, and reference lists of central papers. Terms included epistemic trust, mistrust, credulity, interpersonal trauma, psychotherapy, therapeutic alliance, mentalizing, and epistemic injustice. Searches for named instruments and exact article titles supplemented these topic searches. Foundational papers were retained irrespective of age; recent publications were checked against publisher records. The final bibliography contains 36 sources selected for direct relevance to a theoretical claim, measurement problem, clinical observation, or methodological judgement. This was a purposive search rather than an exhaustive database review, and the bibliography should not be interpreted as a complete census of eligible research.

Priority was given to original psychometric, behavioural, and treatment process studies. Reviews and conceptual papers were included to identify the history of the constructs and competing interpretations. Adult clinical evidence received the greatest interpretive weight. Community and student samples were retained

borderline personality features was not treated as evidence about all survivors of interpersonal trauma. Bibliographic details were checked using indexed records and publisher information; final journal citation years were used where these differed from online publication dates.

Extraction and critical synthesis

For the central empirical studies, the synthesis considered design, population, operational definition of trust, temporal ordering, outcome, and the strongest warranted inference. Accessible full texts were examined for task procedures and important limitations. Quantitative results are reported only when needed to clarify a substantive issue; no effect sizes were recalculated or combined. A distinction was maintained between cross-sectional association, change during treatment, prediction of later outcomes, and evidence that an intervention acts through a specified mechanism. These distinctions matter because temporal and causal conclusions cannot be recovered from the vocabulary of a statistical model alone (Maxwell & Cole, 2007; Kazdin, 2007).

The Findings section presents conclusions from this synthesis. The Arguments section develops the article's proposed interpretation and prospective tests. Tables label published observations separately from proposed assessments. The review has no registered protocol, independent duplicate screening, or formal risk-of-bias scoring, and therefore cannot support claims of exhaustive coverage or a definitive hierarchy of treatment efficacy. Selection may favour accessible English-language research and the conceptual tradition that developed the instruments. These limitations are addressed by retaining discordant findings, examining adjacent accounts of alliance and injustice, and identifying observations that would weaken the proposed framework.

Epistemic trust concerns whether another person's communication is treated as credible and relevant enough to influence learning. It differs from expecting someone to be kind, honest in every situation, or emotionally available. A person can trust a friend's intentions while declining their medical advice, or recognise a clinician's expertise while questioning an interpretation of family life. Sperber et al. (2010) describe epistemic vigilance as a set of capacities for assessing communicated information and its sources. Their account makes critical evaluation compatible with communication. It provides a theoretical basis for treating selective acceptance as a normal requirement of learning rather than regarding scrutiny itself as evidence of relational failure.

Fonagy and Allison (2014) connect therapeutic mentalizing with the possibility that a patient experiences communication as personally meaningful. Mentalizing involves interpreting behaviour in relation to mental states while recognising uncertainty about those states. The proposed therapeutic effect is broader than persuasion within the consultation: learning may become available again in the social environment. Fonagy et al. (2017) subsequently placed this account within a developmental model of resilience and vulnerability. Campbell et al. (2024) further discuss mentalizing and epistemic trust as possible active ingredients across psychotherapeutic approaches. These contributions supply a rationale for investigation, but their explanatory reach should not be mistaken for experimental confirmation that one process accounts for all effective treatment.

The developmental literature also places limits on any assumption that a particular interpersonal style is intrinsically defective. Kurt (2025) uses error management theory to explain why the relative costs of misplaced trust and missed opportunities may shape apparently maladaptive patterns. This is a theoretical account, not evidence that every instance of mistrust is adaptive or that an individual's history can be

adequately without considering both the available evidence and the consequences of being wrong.

Measuring trust without collapsing distinct dispositions

Campbell et al. (2021) introduced the ETMCQ to distinguish trust, mistrust, and credulity. Trust broadly concerns openness to communicated knowledge; mistrust concerns difficulty treating others' communication as dependable or relevant; credulity concerns insufficient discrimination in accepting it. These dimensions are not three successive points on a single scale. A high score on one does not mathematically require a low score on another. The distinction allows a person to report both strong suspicion in some interactions and excessive receptivity in others, although a general questionnaire cannot establish when or why those patterns occur.

Validation studies have supported the usefulness of this multidimensional approach while exposing instability in particular items and interpretations. Liotti et al. (2023) found meaningful associations between epistemic disruption and several domains of psychological difficulty in an Italian validation. Weiland et al. (2024) reported that mistrust and credulity were more consistently associated with distress than trust in their German samples and examined modifications to the original item structure. These findings support continued construct development rather than automatic transfer of one scoring interpretation across languages. They also warn against treating absence of mistrust as equivalent to strong, flexible trust.

The revised ETMCQ-R was evaluated in 525 UK adults and retained an 18-item, three-factor structure after item refinement (Campbell et al., 2025). Associations with general psychopathology were much smaller for trust than for mistrust and credulity. The study improved the measurement basis but remained cross-sectional. A six-item version subsequently examined in 515 community participants offered a shorter assessment, although the reported reliability of its two-item

decision based on a small score difference.

Clinical validation further complicates interpretation. Kumpasoğlu et al. (2026) compared 378 people seeking treatment for common mental health difficulties with 357 community participants. The study supported the three-factor structure but found only partial scalar and strict invariance, alongside a paradoxical association involving the trust dimension. Consequently, comparisons between clinical and community groups require attention to item functioning. Knapen et al. (2024) developed the Questionnaire Epistemic Trust through a different operational approach, reporting four subscales and associations with clinical functioning and alliance. The existence of multiple instruments is productive, provided their scores are not treated as interchangeable indicators of a single established capacity.

From general self report to observed learning

The Epistemic Trust Rating System offers observer-based assessment of psychotherapy sessions. Its development involved 118 patients receiving psychodynamic treatment for depression and identified observable aspects of sharing, relational engagement, and receptiveness to learning (Fisher, Guralnik, et al., 2025). This method helps to examine communication as it occurs. However, a session rating is an observation within a particular relationship. It does not directly show whether information is accurate, whether the patient would reject unreliable advice, or whether an apparent agreement is experienced as freely chosen. Observer training and the distinction between visible participation and unexpressed hesitation therefore remain important.

Fisher, Fonagy, and Zilcha-Mano (2025) analysed 116 patients using different temporal perspectives on epistemic trust. Some associations varied depending on whether the analysis concerned a session snapshot, prediction of later change, or changes within the same patient. Findings included relationships that ran against simple

person answer different questions. Evidence that relatively trusting patients fare better cannot establish that making a particular patient more trusting will improve that patient's outcome.

Behavioural research has now extended this field beyond questionnaires and session observation. Li et al. (2026) studied 273 young adults across two samples with the Balloon Analogue Risk Task for Epistemic Trust. Participants received advice whose accuracy varied, including an early sequence of misleading recommendations. Greater average deviation from advice was associated with borderline features and with self-reported mistrust. The score averaged absolute deviations across trials, so it combined different directions of departure and different advice conditions. The authors explicitly identified trial-level modelling and advice-accuracy calibration as further work. Their findings provide an empirical starting point for discrimination research, not a validated clinical rule that accepting more advice is always beneficial.

Trauma associations and treatment process evidence

Lashani et al. (2026) examined trauma characteristics and epistemic stance in a German population survey of 2,519 participants aged 16 years and older. Analyses used different subsets according to the information required. Early relational trauma showed a particularly strong association with epistemic disruption when trauma type and timing were considered jointly, and credulity contributed to statistical indirect associations with trauma-related symptoms. This is relevant evidence for a developmental formulation. Its cross-sectional design, retrospective reporting, and community setting do not establish a causal pathway or the effect of changing epistemic stance in adult psychotherapy.

Naturalistic rehabilitation research provides observations over treatment. Riedl et al. (2023) examined 249 patients with complete assessments in one centre, while Riedl et al. (2024) analysed 771 patients across two centres. Improvements in

treatment, incomplete follow-up data, and the absence of experimental allocation of the proposed process limit causal interpretation. Two measurements can establish co-occurring change; they cannot determine whether altered trust preceded symptom relief, followed it, or reflected another aspect of care.

Bröcker et al. (2026) studied 912 participants recruited through a mental health application, relating epistemic stance to symptoms, personality functioning, treatment engagement, and perceived clinical relationships. The findings indicate that dimensions of trust contribute information about engagement and relational experience, although the retrospective and self-report design leaves direction unresolved. In a different setting, Franchini et al. (2026) followed 93 university counselling clients through a brief intervention and follow-up. Epistemic stances and alliance were associated with distress trajectories. Neither sample was a direct test of selective trust as a treatment mechanism among adults with established interpersonal trauma, but both help specify the comparators that a future study must include.

Trauma-focused mentalization-based treatment provides a closer clinical context. Smits et al. (2024) described its rationale and practice, and Smits et al. (2026) examined experiences through interviews with six participants and six therapists. Their qualitative findings identified relational and structural conditions that made emotionally demanding work tolerable, alongside variation in symptom change and transfer into everyday life. Such accounts help identify candidate processes and meaningful outcomes. They do not quantify treatment efficacy or establish that epistemic trust mediates improvement. Li et al. (2023) similarly concluded that empirical development requires stronger experimental and intervention research, including attention to change within and between sessions.

Alliance and the distribution of clinical authority

more than 30,000 patients and found a consistent positive alliance–outcome association. Eubanks et al. (2018) found an association between rupture resolution and outcome, while their separate analysis did not establish a significant overall benefit of rupture-resolution training. These results make relational process indispensable to the discussion, but they do not permit trust to be renamed alliance or alliance to be assumed causal in every instance. A proposed epistemic process must explain something beyond these established relational observations.

An additional literature concerns whose account is allowed to count. Carel and Kidd (2014) describe how illness can expose people to unfair credibility judgements and inadequate interpretive resources. Crichton et al. (2017) apply this concern to psychiatry, while Blease et al. (2017) examine healthcare encounters involving chronic fatigue syndrome. The latter setting is adjacent evidence about clinical credibility, not direct evidence about trauma psychotherapy. Together, these analyses show why evaluation cannot focus entirely on a patient's readiness to trust. The reliability, responsiveness, and limitations of the professional also require scrutiny. Elwyn et al. (2012) offer a model of shared decision making that makes patient participation operational within clinical deliberation.

Aim

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Findings

The evidence supports differentiation more strongly than a universal trust target

differently across instruments and populations (Campbell et al., 2021, 2025; Kumpasoğlu et al., 2026). Consequently, a higher general trust score cannot serve as an unqualified endpoint for trauma psychotherapy. This conclusion concerns interpretation, not the rejection of existing instruments. Questionnaires remain useful for describing patterns and generating clinical questions, provided that a score is not asked to determine the validity of an individual decision.

A second finding is that the field has begun to measure epistemic processes in context. Observer ratings and behavioural tasks address limitations of general self-report, but they introduce different interpretive problems (Fisher, Guralnik, et al., 2025; Li et al., 2026). Visible receptivity may reflect genuine reconsideration, interpersonal accommodation, or relief at receiving a coherent explanation. Distance from advice may reflect source evaluation, risk preference, misunderstanding, or prior knowledge. These alternatives cannot be resolved by relabelling the observed response as trust or mistrust. They require designs in which source quality and the patient's own information are independently known.

Table 1 Selected studies and the inference each can support

Study and sample

Observed contribution

Interpretive limit

Campbell et al. (2025)525 community adults

Revised self-report distinguishes trust, mistrust, and credulity.

Cross-sectional validation does not establish a treatment mechanism.

Kumpasoğlu et al. (2026)378 clinical and 357 community participants

functioning.

Li et al. (2026)273 young adults in two studies

Advice deviation relates to self-reported mistrust and borderline features.

An aggregate discrepancy score does not isolate adaptive discrimination.

Lashani et al. (2026)2,519 population respondents

Trauma type and timing jointly relate to epistemic stance.

Retrospective cross-sectional data cannot establish causal mediation.

Riedl et al. (2024)771 rehabilitation patients

Epistemic stance and distress change during routine treatment.

Concurrent changes do not determine direction of influence.

Smits et al. (2026)6 participants and 6 therapists

Interviews describe conditions for trauma work and variable transfer.

Experiences identify hypotheses rather than comparative efficacy.

Samples are those reported by the cited studies, not participants in the present review. Lashani et al. used analysis-specific subsets; the full population sample included participants aged 16 years and older. This table is selective rather than exhaustive.

Existing designs leave the mechanism unsettled

The studies summarised in Table 1 do not collectively establish a causal chain from interpersonal trauma through epistemic disruption to symptoms, followed by recovery through restored trust. Cross-sectional indirect effects describe a statistical pattern; longitudinal observations show that variables can change together; qualitative accounts show how

misrepresent a longitudinal process, while Kazdin (2007) sets out the stronger requirements for identifying therapeutic mechanisms. A plausible developmental narrative cannot substitute for those requirements.

Evidence also varies in its proximity to the clinical question. A population survey containing trauma-exposed participants, a university advice experiment, and an inpatient rehabilitation cohort differ in selection, aims, and the meaning of their outcomes. Findings about borderline features do not define a universal profile of trauma survivors. Likewise, a treatment cohort cannot show that a process is specific to trauma without an appropriate comparison. The evidence supports investigating epistemic stance as one component of formulation. It does not justify a new diagnosis, an exclusion criterion for treatment, or a prediction that a particular person will be unable to benefit.

Decision ownership is not captured by acceptance alone

The synthesis identifies a mismatch between several available observations and the outcome of interest. Existing measures can assess reported dispositions, therapeutic receptivity, or departure from advice. None of these observations, on its own, establishes that a decision remains attributable to the patient's considered reasons. A patient may disagree because the recommendation conflicts with a practical constraint, accept it because its rationale is convincing, or comply because refusal feels unsafe. This article therefore treats decision ownership as a distinct outcome to investigate, rather than assuming it is already measured by trust, alliance, or treatment attendance.

The corresponding clinical interpretation must remain reciprocal. If the therapist offers an inaccurate account or discounts relevant circumstances, lower receptivity may be an appropriate response. Work on epistemic injustice and shared decision making supplies reasons to assess the professional contribution as well as the

from locating every communication failure inside the patient while leaving the quality of the communication unexamined.

The unresolved question concerns discrimination and transfer

Taken together, the evidence supports a bounded research question: does treatment help a patient differentiate communication according to its evidential quality and personal relevance, and does that ability support decisions outside therapy? The question extends existing proposals for selective social learning and behavioural measurement rather than replacing them (Sperber et al., 2010; Li et al., 2023, 2026). Its added emphasis is the joint evaluation of discrimination, the freedom to question, and transfer beyond the clinician's presence. These outcomes could diverge. Better task performance could coexist with greater dependence on the therapist, or greater autonomy could occur without a rise in general trust.

The Findings therefore support a research programme rather than immediate adoption of a new treatment target. No included study validates the full combination proposed here as a clinical endpoint. This statement is bounded by the purposive review and is not proof that no related research exists. The practical requirement is to formulate predictions that existing measures and plausible alternatives could defeat. The next section develops those predictions and considers what would be required before selective epistemic trust could guide assessment, treatment planning, or decisions about ending care.

Arguments

Selectivity is a more defensible target than maximum acceptance

The principal argument is that an intervention concerned with epistemic trust should improve the relation between communication quality and its influence. Average acceptance alone is insufficient. If a person becomes equally more

may conceal lost opportunities to learn. A useful assessment must therefore preserve both kinds of observation. It should ask which information changed a judgement, what evidence supported that change, and whether the response altered when the source's reliability changed. The relevant outcome is a pattern across conditions rather than one high score.

This position follows the logic of epistemic vigilance and extends proposals already made in recent behavioural work (Sperber et al., 2010; Li et al., 2026). Its clinical significance lies in the possibility that symptom relief, social receptivity, and information discrimination may follow different trajectories. A patient might report less anxiety because decisions are temporarily delegated to a trusted clinician. That arrangement can be useful during a difficult period, but it does not demonstrate that the patient can later evaluate unfamiliar advice independently. Conversely, a patient who begins to challenge unsuitable interpretations may become less agreeable during sessions while making more considered decisions outside them. Neither trajectory should be inferred from satisfaction alone.

Selective trust cannot be defined as accepting whatever eventually proves correct. In real decisions, outcomes may be delayed, ambiguous, or partly uncontrollable. A judgement should be evaluated against information reasonably available at the time. A reliable source can make an error, and an unreliable source can occasionally be right. Research must separate sensitivity to a source's track record from hindsight about one result. This prevents a person from being classified as irrational merely because a reasonable decision had an unfortunate outcome. It also prevents apparent success from concealing uncritical acceptance that happened, on that occasion, to produce a favourable result.

The costs of mistakes further qualify the target. Declining uncertain advice about a minor preference differs from declining advice that could

requirements for evidence when the stakes change, rather than reward one fixed level of trust. The proposal is not an optimisation rule for every personal choice. It is a requirement that clinical interpretation account for the reasons a person might reasonably demand greater certainty in one domain than in another.

Self trust includes the capacity to revise a judgement

Epistemic agency is sometimes described as confidence in one's own perceptions or conclusions. Confidence matters, but uniformly increasing it would repeat the problem posed by uniformly increasing trust in others. A patient may be confidently mistaken, appropriately uncertain, or correct but unable to act without reassurance. These states have different implications. The proposed framework uses agency to mean participation in reasoning and ownership of decisions, including the ability to acknowledge uncertainty and change one's mind. An account of recovery that requires unwavering self-certainty would make correction appear threatening and could close the social learning it was intended to restore.

Consider a hypothetical consultation about resuming a demanding social activity. The clinician suggests that avoidance contributes to distress. The patient accepts that possibility but explains that the proposed activity involves a person who has recently behaved coercively. An informed decision may retain the therapeutic aim while choosing another setting. Agreement with the general formulation and refusal of the specific recommendation can both be reasonable. This is an illustrative example, not a clinical case or evidence of treatment efficacy. Its purpose is to show why a single response category such as acceptance fails to capture the relationship between information, personal circumstances, and action.

Decision ownership can be investigated by asking what a patient understood, which reasons influenced the choice, what alternatives were

making provides a practical foundation for this distinction (Elwyn et al., 2012). The framework adds a prospective question: can the person continue to evaluate new information when the professional is absent? Delegating a decision voluntarily may still express agency. The critical issue is whether delegation is understood, revisable, and consistent with the patient's priorities, rather than compelled by fear of losing care.

The boundary between belief and action also needs preservation. A patient may consider advice credible but decline it because the practical costs are unacceptable. Another may follow a recommendation provisionally while remaining uncertain about its rationale. Both responses can be thoughtful. Researchers should therefore record perceived credibility separately from intended and actual action. Otherwise, affordability, family obligations, or limited access to alternatives may be misclassified as mistrust. This separation would make the proposed construct more precise and reduce the risk that an assessment measures compliance with the opportunities available to relatively advantaged participants.

The professional contribution must be open to examination

A model concerned only with how patients receive information is incomplete. The clinician selects what to communicate, how strongly to state it, and how to respond when questioned. These choices can change the evidential and emotional conditions of the encounter. A clear explanation of uncertainty makes a different invitation from an interpretation presented as established fact. A patient who has experienced repeated invalidation may need evidence that a correction will be heard before engaging in substantive disagreement. The hypothesis is reciprocal: patients' capacities matter, and so does the environment in which those capacities can be exercised.

Research on epistemic injustice supports scrutiny of the credibility assigned to patients' accounts

challenge, the patient's attempt to question it becomes further evidence for the interpretation. The proposed framework would instead distinguish factual disputes, differences in values, uncertainty about another person's intentions, and disagreements about feasible action. These categories need not be turned into another diagnostic instrument. Their purpose is to prevent unlike events from being aggregated into a single measure of poor engagement.

Observable professional behaviours could include explaining the basis of a recommendation, acknowledging limits of expertise, asking whether important circumstances have been missed, and revising a formulation when relevant evidence changes. These are proposed coding targets, not a validated intervention package. Ratings should be made by assessors who can distinguish an invitation to disagree from actual responsiveness when disagreement occurs. A clinician can use collaborative language while continuing to disregard the patient's reasons. Similarly, a session can contain a repaired misunderstanding without requiring agreement about every interpretation. The alliance rupture literature provides a relevant comparator for testing whether the proposed observations add explanatory value (Eubanks et al., 2018).

This reciprocal approach also changes how adverse findings would be interpreted. If a patient's reluctance is concentrated around one clinician or one topic, a general patient deficit becomes less plausible. If several patients become unusually compliant with the same therapist, an observer should consider features of that relationship or service before attributing the pattern to patient characteristics. Such analyses require sufficient numbers of therapists and repeated observations; a small sample cannot reliably identify clinician effects. The purpose is accountable interpretation, with conclusions proportionate to the available data, rather than another rating system used to rank professionals from unstable estimates.

without needing external proof. The clinician's task is to clarify which kind of statement is under discussion. Reports of subjective experience deserve serious engagement even when an explanation of that experience remains open to revision. Equally, respecting a patient's perspective does not require endorsing every conclusion. The proposed standard is a transparent process in which reasons can be examined without using professional status to settle the question in advance. That distinction protects clinical reasoning as well as patient participation.

Measurement must distinguish evidence from social appeal

An initial assessment programme should combine established instruments with carefully bounded experimental observations. The ETMCQ-R can describe reported dispositions; the ETRS can describe aspects of in-session receptivity; an advice task can examine responses under controlled conditions (Campbell et al., 2025; Fisher, Guralnik, et al., 2025; Li et al., 2026). None should be treated as the definitive criterion against which all others are judged. Disagreement between measures may be informative. A person may describe general mistrust while appropriately using evidence from a reliable source, or appear receptive in therapy while reporting that disagreement feels unsafe. The aim is to understand those discrepancies, not eliminate them by averaging everything into one score.

For the experimental component, source reliability should vary independently of interpersonal warmth or apparent authority. A supportive speaker and a neutral speaker could each provide advice of differing accuracy within a neutral task. Participants would first make their own estimate and indicate confidence, then view the recommendation and decide whether to revise. Feedback would make the source's track record observable. Counterbalanced sequences could test adjustment after reliability improves or deteriorates. This is a design proposal, not a task

Several competing influences require measurement before a change can be interpreted as selective learning. Task comprehension, baseline accuracy, risk preferences, fatigue, and the discrepancy between one's own estimate and the advice can affect revision. The familiar ratio of movement toward advice can also become unstable when initial estimates and recommendations nearly coincide. A suitable analysis could instead model final judgements while accounting for initial estimates, recommendation distance, and source history. The exact model should follow piloting and parameter-recovery work rather than be selected because it produces an appealing psychological label. Sufficient reliability for the intended individual or group inference is essential (Hedge et al., 2018).

A matched comparison without a human adviser would strengthen the interpretation. Participants could receive equivalent information from an impersonal display, with the same accuracy, uncertainty, and feedback. If changes occur equally in both conditions, improved attention or general evidence use may explain the result more economically than an interpersonal process. If the difference depends on who communicates the information, a social explanation becomes more plausible, although additional alternatives would remain. The comparison should hold informational content constant while documenting participants' beliefs about how that content was produced. Otherwise, a nominally nonsocial condition might still evoke assumptions about an unseen person or institution.

The task should use low-stakes material and transparent research consent. If any inaccurate communication is experimentally presented, its role must be ethically justified and debriefed; the treating clinician should not deliberately mislead a patient as a test of therapeutic progress. More naturalistic observations could use openly identified fictional scenarios or the review of genuine decisions chosen by the participant.

contribute without assigning any single measure authority over the patient's account.

Table 2 Complementary assessment domains in the proposed framework

Domain

Candidate observation

Boundary of interpretation

Reported stance

ETMCQ-R dimensions Campbell et al. (2025)

General dispositions do not establish the validity of one decision.

Session process

ETRS and observation of disagreement Fisher, Guralnik, et al. (2025)

Receptivity does not by itself establish freely chosen agreement.

Information discrimination

Revision under varying source reliability and social appeal

Proposed task extension; requires independent psychometric validation.

Decision ownership

Patient account of reasons, alternatives, and freedom to decline

A proposed interview domain, not an established diagnostic scale.

Clinical outcome

Symptoms, functioning, and a patient-defined decision goal

Improvement must extend beyond learning the assessment task.

Context

impaired agency.

The combined programme is proposed here and has not been validated. Use authorised versions and scoring guidance for established instruments. No proprietary items are reproduced.

Prospective evidence must separate change from explanation

A prospective study could recruit adults entering outpatient psychotherapy who report interpersonal trauma, while recording diagnosis, current safety, treatment received, and the practical context of decisions. Trauma exposure should be characterised rather than reduced to a single yes-or-no item. The International Trauma Questionnaire can assess relevant post-traumatic and self-organisation symptoms when appropriate to the study question (Cloitre et al., 2018); it does not replace an assessment of exposure or a clinical interview. A comparison cohort could help determine whether observed processes are associated particularly with interpersonal trauma or reflect a wider feature of psychotherapy. Trauma itself cannot be randomised, and group differences would remain open to confounding.

Measurements before treatment, during treatment, at completion, and during follow-up would establish a temporal structure. The schedule must be frequent enough to test the proposed sequence without turning assessment into a burdensome examination of every decision. Candidate follow-up points at three and six months are practical design choices, not an empirically established optimum. Alternate task forms would help distinguish learning about information sources from simple familiarity with the assessment. The primary outcome could concern functioning or a patient-defined decision goal, with symptom change and treatment engagement retained as separate outcomes. A task score should not be the only evidence that the task measures something clinically important.

Transfer should be examined at more than one distance from the trained situation. A new adviser

introduces practical and relational conditions absent from both. These comparisons need not yield identical results. Their divergence would help locate the boundary of any benefit. Repeated success in one familiar exercise would support a narrow learning effect, whereas improvement across unfamiliar sources and personally relevant situations would provide stronger evidence for the broader claim about recovery of agency.

Analysis should distinguish stable differences between people from changes within a person. Hamaker et al. (2015) show why conventional cross-lagged interpretations can be misleading when stable individual differences are not adequately separated. The framework therefore predicts that a patient's improvement in discrimination should precede a relevant improvement in functioning, above what is explained by earlier functioning and symptom burden. Even this temporal pattern would remain insufficient for a causal claim if unmeasured circumstances changed both. Data on alliance, treatment intensity, social support, and significant life events would improve interpretation, while a prespecified causal rationale should determine which variables are adjusted rather than indiscriminate statistical control.

Sample size should be planned using the reliability of the measures, expected within-person variation, therapist clustering, missing data, and the smallest clinically useful association. This review supplies no defensible effect estimate for a definitive power calculation. A feasibility phase can estimate burden and measurement properties; a separate confirmatory study should test the resulting specification. Participants who discontinue treatment or miss assessments are especially important because the process of interest may affect participation itself. Their available data and reasons for withdrawal should be examined, with sensitivity analyses for plausible missingness patterns. Excluding them would risk studying trust only among those most willing to remain in the research relationship.

further question remains: does using this information improve care? A study could compare usual formulation and outcome monitoring with the same care supplemented by structured review of source evaluation and decision ownership. Both groups must retain ordinary standards of informed consent, collaboration, and respect. The comparison should not withhold a basic right to question treatment. Where additional clinical time is required, an equal-contact comparison would help determine whether benefit comes from the proposed assessment or simply from greater attention. Treatment choices should be documented so that researchers can examine what the new information actually changed.

Clinically meaningful outcomes might include participation in valued activities, more considered help-seeking, improved communication of disagreement, or reduced dependence on repeated reassurance. These should be selected with patients before outcome data are examined and should not all be collapsed into a single favourable narrative. A person may reasonably seek more help after recognising a previously minimised problem. Another may need fewer appointments after gaining confidence in a decision. Counting either more or less service use as universally better would misinterpret the goal. Measures of burden, unwanted influence, and loss of decision ownership should accompany symptom and functional outcomes.

There are straightforward ways for the proposal to fail. Existing alliance measures might explain the relevant outcomes just as well, leaving no reason to add a new assessment. Task discrimination might improve without any change in daily functioning. Reported agency might increase because patients learn the preferred vocabulary of the service. An intervention might produce more questioning but also greater paralysis, consuming time without making choices more informed. These results would limit the framework even if participants found its language attractive. Table 3 states candidate predictions alongside

challenge the proposal

Claim to test

Supporting pattern

Pattern that weakens the claim

Selective learning

Information quality influences revision beyond warmth or authority.

Acceptance rises regardless of information quality.

Interpersonal specificity

Effects differ meaningfully from a matched nonsocial condition.

General attention or task learning explains the same change.

Temporal relevance

Discrimination changes precede later functional gains.

Functional improvement precedes the proposed process.

Transfer

Benefits extend to unfamiliar sources and patient-chosen decisions.

Changes remain confined to the familiar task or therapist.

Added clinical value

Using the assessment improves outcomes beyond equal-contact care.

Existing measures perform as well, or burden outweighs benefit.

All entries are prospective hypotheses. The present article reports no experiment or treatment evaluation testing these predictions.

Recovery must remain possible under uncertainty

be fully predicted. Patients do not need to become expert judges of every source to benefit from psychotherapy. A more realistic aim is to improve their ability to seek relevant evidence, recognise the limits of a recommendation, and make choices they can understand and reconsider. Some uncertainty will remain. The framework is useful only if it helps clinicians distinguish a remediable difficulty from the normal burden of deciding under imperfect conditions.

Preserved capacities provide an important counterexample to a universal account. A trauma-exposed patient may evaluate sources accurately from the outset and still experience substantial distress. There would be little reason to make discrimination the principal target for that person. Research should examine whether any added benefit is concentrated among participants with a demonstrable difficulty at baseline. Such moderation requires a prespecified interaction and sufficient precision; a favourable result in one small subgroup would not establish a selection rule. Improvement among people whose discrimination remains unchanged would also show that recovery can proceed through other processes, limiting claims that this capacity is a necessary mechanism.

Changes in the social environment offer another competing explanation. Access to dependable support or a less coercive setting may make decisions easier without changing an underlying capacity to judge information. That is a valuable outcome in its own right. A formulation should record it rather than assign the entire improvement to an internal psychological process. The same reasoning applies to services: clear information, continuity of care, and usable opportunities to raise concerns can make appropriate trust possible. Research that measures only patients' scores would miss this contribution and could overestimate what an individual intervention accomplished.

Social context places further limits on interpretation. A person with restricted income,

disability, and cultural expectations can affect how disagreement is expressed. Clinical assessment should therefore allow explanation, postponement, or an interpreter rather than equate verbal fluency with agency. A self-report measure validated in one language or setting requires appropriate evaluation before it is used to compare other groups. The partial invariance reported by Kumpasoğlu et al. (2026) illustrates why this is a measurement issue as well as a matter of fairness.

Finally, epistemic agency must apply to the framework itself. Patients should be able to question whether its description fits their experience, decline an optional research task, or prefer another formulation. Their disagreement cannot be used as automatic confirmation of mistrust. The framework offers a set of questions about communication and choice, not a privileged explanation of every relational difficulty. Its strongest justification would be evidence that patients use trustworthy information more effectively while retaining the freedom to identify error, set boundaries, and pursue their own goals. Without that combination, greater receptivity would remain an incomplete account of recovery.

Argument

This section should be reviewed during editorial preparation. If the original manuscript does not provide this section separately, the editorial office should decide whether the existing article content already covers it or whether author-approved expansion is required.

Conclusion

Epistemic trust has become an empirically accessible subject through questionnaires, observer ratings, behavioural tasks, and research on psychotherapy processes. The literature supports distinguishing trust, mistrust, and credulity, while also showing that their clinical

investigation. They do not establish that increasing acceptance of another person's communication is, by itself, a mechanism of recovery after interpersonal trauma.

This article has argued for a more specific evaluative aim: learning from credible and relevant information while preserving the capacity to question it and retain ownership of decisions. Selective trust is not a new diagnosis or a requirement to distrust authority. It is a candidate process through which openness and judgement may become better coordinated. The corresponding assessment must examine what the clinician communicates, how uncertainty is represented, and whether a patient's reasons can influence the formulation. Otherwise, increased agreement risks being mistaken for an improved capacity to learn.

The proposed research programme begins with measurement that separates source reliability from social appeal and distinguishes belief revision from action. It then requires prospective evidence that changes matter beyond symptom relief, alliance, and task familiarity. Any clinical application must finally show that using the information improves patient-valued outcomes without increasing burden or unwanted dependence. Negative or null results would be consequential: if existing measures explain the same outcomes, or better discrimination does not benefit daily life, the proposed framework should be narrowed accordingly.

The immediate contribution is therefore a clearer standard for interpreting therapeutic influence. Recovery can involve accepting help, disagreeing with a recommendation, postponing a decision, or revising an earlier belief. What matters is whether those responses become more responsive to evidence and circumstances and more meaningfully attributable to the person making them. For adults whose interpersonal experiences have made their own judgement difficult to sustain, that standard preserves an essential purpose of psychotherapy: a life in which learning

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