

Beyond sensorimotor imitation in the neonate: Mentalization psychotherapy in adulthood

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Abstract: Despite the persuasiveness of Keven & Akins' (K&A) review, we argue that mentalization, or the ability to interpret the mental states of oneself and others, is required to construct the neonate mind, going far beyond sensorimotor imitation. This concept, informed by certain psychoanalytic and attachment theories, has produced a form of therapy called *mentalization-based psychotherapy*, which aims to improve emotional regulation. Our aim here is to shed light on a form of neonatal imitation that goes beyond sensorimotor imitation.

From birth, “instinctive” behaviors have a double explanation, partly attributable to heredity (genes) and partly to the environment: The innate potential to develop behaviors, and behavioral acquisition and development, respectively. Gene-environment interactions normally explain interindividual behavioral differences, according to human behavioral genetic research (McGue & Bouchard 1998).

Very early on, as in imprinting (Lorenz 1935), heredity and environment interact. Some interactions occur in periods considered critical, being of limited duration and essential for subsequent normal development – for example, of language and vision. Many cerebral structures have critical maturation periods, corresponding to critical development periods for cognitive or executive functions, which enable cerebral plasticity (Hensch 2016). Cerebral plasticity may be newly available by reactivating critical periods using pharmacology, exercise, or psychotherapy.

Mentalization-based therapy identifies precocious mentalization mechanisms in neonates and children and attempts to modulate them in adults through psychotherapeutic interactions (Desseilles et al. 2015).

The critical interactions between adults and neonates depend on the neonate's behavioral capacities for social interaction (Brazelton 1987). At birth, neonates turn their head towards a human voice, are attuned to the pitch of a female voice; prefer human to pure sounds; fixate on images of the human face; turn towards the smell of milk; and so on. The neonate already interacts as an individual. For Brazelton, parents should be aware of their newborn's wakenings and sensitivities. Recognizing the neonate's competencies allows obtaining a starting point for interaction and imitation, both sensorimotor and psychic.

The capacities described by Brazelton corroborate those that Bowlby (1978) described as attachment, reflecting the quality of relationships established with others from birth through childhood and even adulthood (Zelinka et al. 2014). A key concept here is the internal working model: Mentalizing includes the abilities (1) to interpret the other's psychological characteristics; (2) to infer and attribute to the other desires, emotions, beliefs, and intentions; and (3) to differentiate and understand these mental states in the other and oneself. Children apply these models to various situations in order to predict their own and others' behaviors. Bateman and Fonagy (2006) called this interpretive *mentalization*, or the *interpretive interpersonal function*, arising from interactions with attachment figures.

Bateman and Fonagy (2006) contended that, at birth, humans are unaware of the different emotional states, and that they

learn through interactions with others, chiefly primary caregivers. Emotional states are learned by “mirroring” bodily sensations associated with emotional states, which the caregiver provides, particularly through facial mimicry and emotional aspects of the voice (resonance). This forms the basis for emotional regulation (Desseilles et al. 2015, p. 203): “I don't know where Mommy is, which gives me a stomachache and makes me cry. I see my Mommy, with tears in her eyes, who tells me ‘Don't cry, Mommy's here! I deduce that what I feel is grief, and I label it as such.” When children have difficulty with emotional learning, they incorrectly attribute emotions to bodily signals and have difficulty regulating emotions as adults. Mirroring enables children to develop appropriate emotions and emotional interpretations as the caregiver shapes and gives meaning to their internal experience. This provides emotional representations that are internalized in the psychic functioning, and that form the bedrock of the child's identity, or self. Emotionally neglected children, such as borderline personalities, lack a stable structure of the self. For normal development, children need exposure to significant individuals whose emotions they can represent within themselves, and who, in a caring and benevolent manner, can reflect their feelings and intentions appropriately, without overexaggeration, which may lead to overidentification with the other.

Children who lack adequate caregivers have problems distinguishing reality from fantasy, or physical reality from psychic reality. Bateman and Fonagy (2006) called this the *alien self*, or confusion with the other: internally experienced ideas and feelings do not seem to belong to the self. The child may then integrate the part of the other that feels like a stranger.

If children fail to learn that internal experiences exist in the mind and not in the external world, they may believe that the internal and external world are one and the same, with no differentiation between the imaginary and the real. Physical reality becomes “too real.” Moreover, in pretend mode, the mental state is completely separate from the external world, and external physical reality becomes “too unreal.” Normally developing children integrate the two modes to develop reflective mentalization, whereby thoughts and emotions are experienced as symbolic representations, such as words. Internal and external reality are experienced as simultaneously related and separate, and no longer need to be even similar or dissociated from each other. However, patients with borderline disorder do not integrate the two aspects, by default, and they function either in psychic equivalence or pretend mode.

The aim of the mentalization-based therapeutic approach is to reinstate the mentalizing process. Therapists should continuously ask themselves why the patient is saying something. What is the reason for the behavior? Why does the therapist simultaneously feel what the patient feels? Therapists strive to understand what is disturbing their patients, how to identify and give meaning to their experience, and how to clarify it to them. Therapists must also accept enacting the transference experience, evoking the alien self. Therapy takes place in the here and now, not the past or future. Therapists must not interfere with their patients' mental states, but instead accept their thoughts and feelings. Therapists help their patients name, describe, and understand emotions and situate them in current or recent contexts. Thus, the patient's mind is explored by another mind (the therapist's) through interpersonal interactions that are caring and non-threatening, with the therapist's clear explanations using metaphor-free vocabulary, such that the patient fully understands what is happening.

This therapy should not be neglected, because it leverages a neonate's capacity to understand facial emotions and intentions of the primary caregivers and consequently to develop emotional regulations on the ground of these basic experiences essentially made from these imitations (psychic imitation, sensory imitation, and motor imitation). Because language is not yet developed in neonates, these mentalization experiences are able to connect the body and the mind. This opens a very promising avenue for future new psychotherapies, as, for instance, involving facial retroaction feedback and/or attentional training, such as mindfulness, and/or other emotional regulation strategies (Mikolajczak & Desseilles 2012; Desseilles et al. 2015).