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REVIEW

MENTALIZING AS COMPLEX EMPATHY IN INTERPERSONAL COMMUNICATION

Jozef Hašto[1, 2, 3]

[1]*University of St. Elizabeth, Bratislava, Slovak Republic*
[2]*Slovak Medical University, Bratislava, Slovak Republic*
[3]*Palacky University in Olomouc, Czech Republic*

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Abstract
Secure attachment is the best breeding ground to develop the mentalizing capacity and seems to be an important factor of resilience. It evolves from a positive relational experience with key attachment figures, who also show these characteristics which are manifested in their sensitive nursing and relationship behaviour. It is believed that the knowledge of the attachment and mentalizing concept is crucial in prevention and treatment of psychiatric disorders, including interruption of their transmission through generations.

Key words: *secure attachment; sensitive mother; mentalizing; psychotherapy; transgenerational transmission; prevention*

INTRODUCTION

Biopsychosocial model and transgenerational effect

Reflecting on the development of an individual, whether in terms of health or disease, it necessarily brings out the issue of understanding conditions in intrauterine and prenatal development and in early childhood. As rightfully pointed out by Professor Peter Fedor-Freybergh (2013), founder of prenatal psychology and medicine, we should go even further:

"... life of a human being begins no later than in the second generation, before their own life, in the house of their grandparents from his mother's side and from his father's side." He thinks not only of *"...genetic and chromosomal determinants, but also of the most important psychosocial phenomena, such as attitudes to life, moral and ethical standards, philosophy of life, respect for all life..."* (Fedor-Freybergh 2013, p. 3).

Thus his view and approach is *bio-psycho-social*. He takes into account chemical-molecular, biological, mental-psychodynamic and interpersonal-social levels as well as the *transgenerational* aspect (familial-genetic-chromosomal level, but also the issue of the so-called social heredity, i.e. learning of things already acquired and passed down from generation to generation).

Recent findings in molecular biology show, inter alia, that it is possible that ill-treatment in childhood (abuse, neglect) can alter gene expression in the brain by the mechanism of DNA methylation and modification of histones (proteins that bind to DNA), including the expression of those genes that control the action of cortisol, the stress hormone (Minárik et al. 2009). An individual affected in this way can, in turn, affect the behaviour of their offspring. Epigenetics has become a hot topic in biology.

Secure attachment, mentalizing as complex empathy and mirror neurons

When I give lectures about the explanatory power of John Bowlby's attachment

theory and about the possibilities of a deeper understanding of mental and psychosomatic disorders in childhood and adulthood offered by this fruitful theory, I am often asked about the optimal shaping of the parent-child relationship in early childhood and about the first years of life for healthy development of the child and good development of his resistance and resilience for later life. And here we come to the importance of the *quality of relationship* between the parent(s) and the child and the quality of parental behaviour, either of the mother, father, sibling, grandparent or foster parents. The quality of the relationship is manifested in the style of communication.

According to Bowlby's theory (review by Hašto 2005, 2006), experience from interactions with the parental figure are internalized in us, stored in our CNS (Hrubý et al. 2011), in our implicit memory as "internal working models" that govern our attachment behaviour even in new relationships. This experience determines our emotions, fantasies, vegetative reactions, motor patterns and expectations in relationships.

In terms of transactional analysis and its terminology (Schlegel 2007), secure attachment can be described as the "inner supportive parent" as an element in one's personality.

Empirical data suggest that *secure attachment* of the child to its parent is something that shapes the child for optimal and healthy development of later relationships, protecting it from developing complicated relations that might be destabilizing or even pathogenic. It turns out that parental ability to develop secure attachment in the child is linked to their own style of secure attachment, which was the easiest to obtain for the parents, if they themselves have had parents (i.e., we are talking about the child's grandparents) with secure attachment.

How to describe a person with secure attachment?

A "strange situation test" (Ainsworth 1985) can be applied in childhood in children aged 12–18 months to observe special behavioural signs that confirm basic confidence of the child that the mother is available, that she can be used as a safe base, a safe harbour. When the mother suddenly leaves the room, the child starts to worry after a while and is looking for her. When the mother returns (after 3 minutes in the test setting), the child joyfully greets the mother and quickly calms down. Immediately afterwards, the child continues its playful and exploratory behaviour in the room with toys. For children aged 6 years, the child will remain easy and open towards the figure it is securely attached to even after one hour of separation. Secure attachment in adults tested by AAI (Adult Attachment Interview) is either a smooth continuation of secure attachment from childhood, or it has evolved as a correction of insecure attachment as a result of deep and thorough processing of negative experiences from the childhood. These people are in good contact with their emotions and are able to integrate negative experiences with the fundamental positive attitude (Fremmer-Bombik 1997).

Studies on *secure* attachment in adulthood (sometimes also referred to as *autonomous* or *free* attachment) using a challenging Adult Attachment Interview (AAI) led to the finding that these favourable attachment experiences and trends are usually associated with a good capacity to *mentalize*, which is likely to become an important mediator modulating situationally appropriate formation of reactions in relationships (Fonagy et al. 2002, 2009, Allen 2009, Munich 2009). The issue of mentalizing and mentalization will be discussed later. Let's just mention at this point that the concept of mentalization can be understood in simplified terms as a much differentiated extension of the concept of empathy. Basic empathy is understood as the ability to share other person's feelings or to enter into other person's feelings. According to new neurobiological findings, it is closely related to the function of mirror neurons (Minárik et al. 2008). In terms of mentalizing, the extension refers in particular to the inclusion of empathy towards oneself.

So what are the characteristics of attachment behaviour of a mother who will typically bring up a child with secure attachment and good foundations to develop the mentalizing capacity?

Sensitive mother/parent/person for attachment

Mary Ainsworth (1985), a co-worker of John Bowlby, labelled such caring behaviour as

sensitive. It is actually healthy and *delicate* subjective experience and behaviour.

M. Ainsworth characterised this desired *sensitive caring behaviour* by 4 key features:

1. The mother must be able to *perceive* signals from the child with *utmost attention*.
   A failure can occur here mainly in delayed perception by the mother when she is engaged or forced to engage in certain external and internal needs and conditions. The mother, who is worried by her own illness or by improper conduct of her husband, or by his illness or her depression, is unlikely to be able to devote full attention to the child and her responses will be delayed. For example, her responses to mimics, movements and voice signals of the child will be slow and retarded. Dissatisfied mewls and puke of the baby will be unanswered and the mother will respond only to a desperate cry.

2. She must *correctly interpret* signals from the child's point of view. For example, when the baby cries, she should infer the meaning of the cry (hunger? discomfort? pain? boredom? need of interaction? need to be in the parent's arms and feel the swaying motion of walking?).
   To derive to correct interpretation of the signals from the child's point of view requires the ability of empathy in the mother/parent, sometimes even patient attempts trying to interpret the signals correctly by trial and error.
   There is a risk that the mother will distort or misinterpret signals from the baby due to her own needs and projection of her needs to the needs of her child. Another problem occurs when the mother has, for example, certain deficits in her subjective experience (and manifestation) of gentle feelings.

3. She must *respond appropriately* to signals from her child, for example, to find the right amount of food, to soothe or offer a game, without making the interaction more difficult by hyper- or hypostimulation.
   Appropriateness refers in particular to the intensity and duration of the reactive interaction. For example, it is inappropriate if the mother overfeeds the child or does not respect the child's need to withdraw from communication (usually indicated by the baby turning its eyes and head away). One can easily imagine excessive soothing behaviour continued by the mother even if the baby no longer needs it. Such behaviour is used rather to satisfy the mother's need of closeness, but causes discomfort in the child. Such hyperstimulation behaviours may give rise to different types of resistance, resulting, for example, in angry crying, vomiting, or resignation behaviour. Hypostimulation leads to frustration in the areas of unsatisfied needs and to various forms of secondary processing.

4. The response must be *prompt* within the range of tolerable duration of frustration.
   For example, the ability to wait for breastfeeding is very short in the first weeks after birth, but it gets loner over the year. New needs emerge in the course of ontogenetic maturation of the child and their intensity varies. Indeed, the mother's role is not easy and it requires her continual openness to empathic perception of her child, trying to identify the baby's needs. There is a misconception among some mothers that a prompt response to baby's needs will "spoil" the child. This is an unnecessary concern, provided that the mother is able to sense the necessary degree of response. The child has a healthy innate tendency to experience life and behaviour, including the tendency to develop autonomy. It also has a natural tendency to learn from the parent; the parent is a model for the baby.
   Chart 1 is a diagram outlining development of child's needs until the old age, as summarised by the German ethologist Hassenstein (2001, p. 17). Naturally, the chart does not include all instinctive needs relevant in the development.

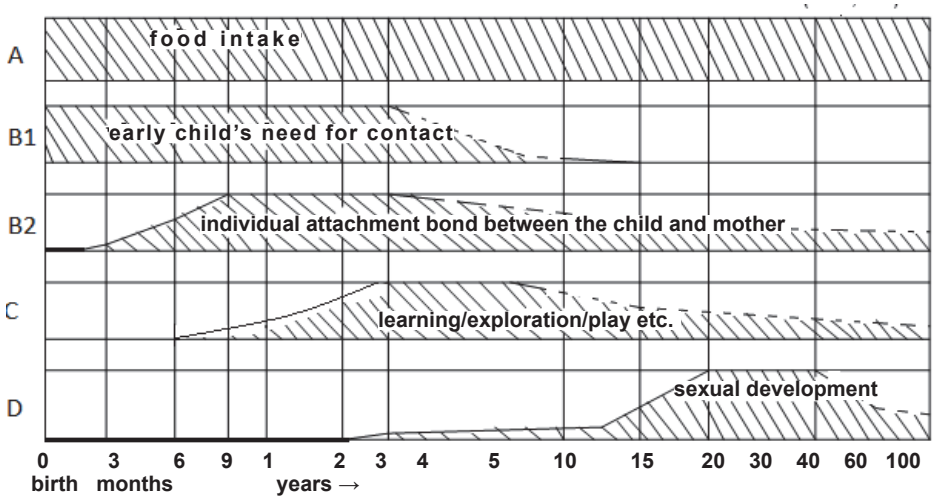

Chart 1. Development of certain areas of human behaviour in terms of socio-biology – freely adapted according to Hassenstein (2001, p. 17)

This is a greatly simplified diagram of the development of some important areas of behaviour in child's life. The dashed sections of the curves show only general progression tendencies. The B1 mark concerns only the early form of contact in children (with a caring adult) and it does not reflect later tendencies to correlate with peers (Hassenstein 2001, p. 17).

From the experience of a sensitive mother/parents to mentalizing

As mentioned above, delicate (sensitive) maternal behaviour towards the child correlates with the mother's secure attachment and correlates with a well-developed capacity to mentalize (Fonagy 2009). It is likely that such a mother experienced a sensitive maternal behaviour from her mother, making it easier for her to cope with her maternal/parental role. It seems, however, that even some mothers who did not have a "good enough mother" are able to reach desirable corrections thanks to quality empathetic relationships in later life, and to develop a fully-fledged ability of empathy. It would, therefore, involve a subsequent development of the mentalizing capacity as complex empathy. This would result in such childcare that helps build secure attachment in the child, laying the good foundation for mentalization. A sufficient, intense and long-term positive attachment experience in later life will actually prevent transgenerational transmission of insecure or traumatized (disorganized) attachment.

The concept of mentalization – or better, the concept of mentalizing to emphasise the process aspect of what is happening – has been identified above as an extension of the current notion of empathy. Mentalizing, therefore, can be seen as complex empathising with another person – or to use psychoanalytic terminology – with an object. We are now interested in the object of the child in its early developmental stages. It is, therefore, about *identifying with and entering the subjective world of the child*, what is often accompanied with *verbalization* by the mothers, as if they spoke for the child and its needs. Plural forms of "we" are often used (e.g. "We are hungry"). At the neurobiological level, functioning empathy can be viewed as a sufficient connection with functioning mirror neurons.

The concept of mentalization as complex empathy (Allen 2009, Fonagy 2009) can be shown in a diagram, as in Chart 2.

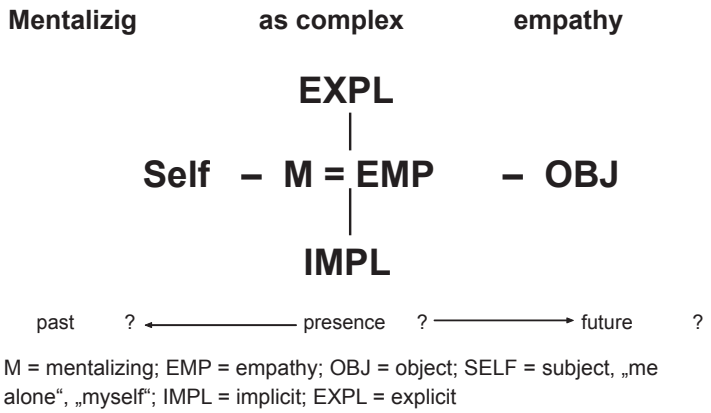

Chart 2. Mentalizing as complex empathy

In addition, the concept of mentalizing involves *empathy towards oneself*! It is therefore about reflecting one's internal states in relevant situations. Empathy, whether towards an object or towards oneself, has its *implicit* and *explicit* side. At the *implicit* level, empathy is experienced as a physical feeling, as a certain inclination to behaviour, as an emotion or a fantasy. At the *explicit* level, we are able to verbally describe what we observe in us or in another person; we are able describe relevant emotions well. Yet the concept of mentalizing is even broader and includes the dimension of time. Our empathy, whether towards an object or towards our self, may include not only the *presence*, but also events, situations and experiences from the *past* and even those in the anticipated *future*.

Deficits in mentalizing and psychopathology; outputs for prevention and psychotherapy

There are reasons justifying the hypothesis that underdeveloped mentalization can lead to a *mental disorder* or represents a risk factor for such disorder. On the other hand, mental disorders usually reduce the capacity to mentalize for the time of their duration (Halsam-Hopwood et al. 2009). Considering this, *vicious circles* may arise (cybernetically speaking, regulatory circuits with positive feedback), which may contribute to persistence of the pathology. *Psychotherapeutic and prophylactic programmes targeted to development of mentalization* are currently intensively researched. Their practical usefulness for mothers with insecure attachment and deficient mentalization is examined. The results are promising so far – see, example, Fonagy et al. (2002), Allen (2009), Fonagy (2009), Halsam-Hopwood et al. (2009), Sadler et al. (2009).

Psychotherapeutic and prophylactic interventions based on the attachment theory are described, for example, by Brisch (2011, 2013). Educational materials for families on the importance of relationships start to emerge (e.g. Velemínský et al. 2010).

Pinched finger – pseudo-mentalization and mentalization

Let us conclude with one more example of failed mentalization of a mother in a situation where her son got painfully wounded, followed by an example of appropriate mentalizing in that situation. I will use the example described by Sadler et al. (2009), complemented with my remarks on other contexts and commentary.

The son trapped his finger in the door and is crying.
Mother: "Don't fake!" and makes fun of him trying to imitate him.

(An example of *pseudo-mentalization*; analogous behaviour of the therapist = complementary negative countertransference, which does not help to achieve a therapeutic change, unless it is reflected and the therapist changes their behaviour.)

The son trapped his finger in the door and is crying.
Mother (friendly and considerately): "Ooh that hurt. You're kinda' scared and want Mommy to make it feel better."

(An example of successful *mentalization*; analogous behaviour of the therapist indicates a concordant countertransference, assuming the ability to contain, i.e. to preserve basic inner peace, although the subject empathises with strong affects of the object.)

Note that the mother in this second example was able to perceive and correctly assess the situation from the perspective of the son, empathetically felt his pain and verbalized it for the child: "Ooh that hurt." She feels his fear and anxiety: "You're kinda' scared." Maybe she even noticed the son's motion or glance toward her and correctly reads his innate tendency to be close to his mother, that is the activation of his attachment behaviour, his search for solace and safety in a stronger and more competent person, when she says "... and want Mommy". And this perfectly mentalizing mother mentions even the teleological aspect, i.e. the purpose of the attachment behaviour, and anticipates its outcome for her son: "... to make it feel better" (Fig. 1).

Fig. 1. Sculptor Henry Moore (1898–1986) deals very thorough with the mother-child relationship in his work. What does this child feel? What does his mother feel?

Complex empathy for psychotherapists and routine clinical practice

Accurate mentalizing in an emergency can be a vital experience for a person, which keep them warm and gives them a great impetus and source of peace and strength. It can be assumed that successful psychotherapists have well-developed complex empathy. Of course, it is desirable to cultivate it in doctors and nurses in clinical fields.

CONCLUSION

Research inspired by Bowlby's theory of attachment has given us remarkable body of knowledge about the vital importance of quality of interpersonal relationships to understand risk and protective factors in the development of personality, clarifying the importance in terms of vulnerability and pathogenesis of psychiatric and psychosomatic disorders and

also for behaviour at times of disease. This knowledge is already reflected in prevention programs and result in new understanding and developments in psychotherapy, not only in psychodynamic approaches. Application of the mentalizing concept in terms of complex empathy appears to be desirable also in routine clinical practice.

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Contact:

Jozef Hašto, Pro mente sana, Pod Brezinou 84, 911 01 Trenčín, Slovak Republic
Email: j.hasto.tn@gmail.com