Relevance of Infant psychiatry to adult psychiatry

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From Adulthood back to Infancy

Fonagy has shown the link between secure attachment, mentalization, the development of theory of mind and empathy, and personality disorders (Attachment and Psychoanalysis).
The link between early experiences, especially attachment experiences, and the development of major brain structures responsible for emotions regulation, is the biological basis of the relevance of infant psychiatry core concepts to Adult psychiatry, especially to personality disorders and psychotherapy.
A significant correlation has been found between disorganized pattern of attachment in childhood, experiences of abuse and/or trauma, and Borderline Personality disorders in adulthood (Fonagy, 1999).

It has also been found that disorganized attachment behaviors in infancy are important precursors of later post-trauma dissociative symptomatology.
In a sample of 524 adult patients with PDs, Bradley et al (2005) found that instable family environment, parental psychopathology, and history of abuse, all independently predicted borderline personality disorders symptoms. Sexual abuse contributed to the prediction of BPD over and above family environment.
One of the main mediating factors of the link between disorganized attachment and the later development of personality disorders is the impairment in the abusive parent’s capacity for mentalization that is transmitted to the child (Fonagy & Target, 1997).
Mentalization and reflective functioning involve cognitive components, including the acquisition of a Theory of Mind (Leslie et al, 2004), as well as affective components, such as empathy, that develop from the earliest affect regulating attachment relationships between infant and caregiver.
Parents’ role in the development of theory of mind

- Young children acquire theory of mind abilities at an earlier age if their parents frequently use expressions referring to mental states ("Parental reflective functioning") (Fonagy, 1997; Carpendale et Lewis, 2004).

- Parental reflective functioning necessitates the parental theory of mind.
Clinical vignette

When a BPD young adult becomes a mother...
Clinical vignette

- Two-months old baby and mother referred to IMH unit by community nurse. Baby cries a lot, Mum looks tense, sad, and at loss. Nurse suspects PPD, describes family as a “hard-to-reach” one.

- First session is a home visit. One room apartment, in mess. Baby cries, Mother takes her to breast, and says: “Even breast-feeding does not calm her, I’m really bad at it, she knows it”.

- Question about Baby’s name reveals the mother’s pathological grief over her only sister’s killing in a car accident 10 years ago.
Mother’s Traumatic attachment experiences

- Disorganized attachment with drug-addicted own mother.
- Ignored by father who left home (when she was about two years old).
- Emotional and Sexual abuse by stepfather.
- Negative experiences with other caregiver figures at boarding school.
Pathological parental projections on infant

- Baby was born in order to continue late sister’s existence (a “replacement” child).
- Baby’s cry reminds the mother of her sister’s tendency to cling to her and to cry. (ambivalent relationship).
- Baby sleeps with mother because “nights are dangerous”. Perceives her husband as potential harmful to child.
Starting an insecure attachment to mother and father

- Mother’s projections on child impinge on her ability to be a consistent protective figure for child.
- Frightening “missed” accident to child: mother forgets to tie baby in her strolley.
- Difficulty to put limits because saying no to child reminds her saying “no” to sister on the day of the accident.
- Marital relationship is tense, father has hx of physical abuse by own mother and distant father.
Intervention in the first three years of life may stop the transgenerational transmission of PDs

- The goal of the parent-infant treatment is to “break” the transgenerational transmission of poor basic trust, by:
  1. Identifying the parental distorted projections on the child.
  2. Identification of the maladaptive, frightening/frightened parenting behaviors.
  2. Giving developmental guidance to give parents knowledge and improve their parenting skills.
Psychopathy continuity from early childhood to adulthood

- Frick et al (1994) defined psychopathy as a developmental disorder because it can be identified in both childhood and adulthood. *It is not synonym of Conduct disorder (CD), nor of Antisocial Personality Disorder (APD):* only approximately 25% of individuals classified with either CD or APD will show psychopathic tendencies (Hart & Hare, 1996; Kotler & McMahon, 2005).
A core feature of psychopathy in children as well as in adults is their excessive use of **instrumental aggression** (purposeful, planned, and goal-directed, **affect less**).

In contrast, **reactive aggression** (i.e., defensive, impulsive, **affective**), is usually caused by frustration, threat, and anger. It is accompanied with negative affect.

Instrumental, as well as reactive, aggression may be seen already in preschool age children.
The main personality-based factor that seems to be genetically mediated is the **Callous/Unemotional** component of psychopathic tendencies: Viding et al, 2005) have found in their almost 3500 twin pairs (The Twins Early Development Study (TEDS), that genetic factors accounted for two thirds of the difference between 7 yrs-olds C/U children and non C/U children.

Some of these children may exhibit only the C/U traits without conduct disorder.
The development of CU traits has been linked to both genetic and environmental factors:

- Exposure to early life very poor caregiving and/or institutional rearing, is the a major pathway to development of CU traits and psychopathy (Bowlby, Winnicot, Ainsworth), as the lack of available and responsive caregiver may disrupt experience-expectant socialization processes related to the development of empathy in the child’s brain.
Children raised in Bucharest institutions from birth were randomly placed, at the age of 22 months, to either foster care with professional guidance (n=68) or to care as usual (n=68). CU traits were assessed at age 12.7 in children from the randomized sample (n=95) and children who were never institutionalized (n=50).

CU traits were assessed with the Inventory of CU Traits.
Results:

- Children who were raised in institutions in their infancy had significantly higher levels of CU traits in early adolescence as compared to children who were never institutionalized.

- Among the sample of institutionalized children, BOYS in the intervention foster care families had significantly less CU traits than those from the care-as-usual. Caregiver responsiveness to distress, but not caregiver warmth, mediated the intervention effect on CU traits in boys.
- These findings provide the first evidence to date that psychosocial intervention can prevent the onset of CU traits.
- Although severe early deprivation predicted higher levels of CU traits, *high-quality foster care* that emphasized responsive caregiving reduced the impact of deprivation on CU traits development in boys.
- *Caregiver responsiveness to distress* is more specifically linked to empathy, social competence, and self-regulation than warmth.
- It is not clear why this effect has not been found among girls.
Infant research and Adult psychotherapy

- **Longitudinal research** from infancy into adulthood provides evidence-based knowledge that basic processes of inter-subjectivity at the nonverbal level remain amazingly similar across the life span (Beebe and Leechman)

Patterns of experience are organized in the infant’s brain as “schemas-of-being-with” (D. Stern, “The Interpersonal World of the Infant”, 1985), that along the first year, become “expectancies of sequences of reciprocal exchanges”.
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Then, in any significant human interaction, each partner comes to expect patterns of response where each one affects and is affected by the other with a specific timing and emotional tone.
These expectancies have become part of our core self (whether integrated or not), as the part of our infancy which remains in us, mostly unconscious, and that is at the basis of our relatedness with others.

The Inside Baby is by essence nonverbal, and manifests itself through affects, mimics, and body configurations.
The adult’s “Inside Baby”

- We propose to name so, those expectancies of interactional sequences with our own parents and with significant others, that have been embedded in the nonverbal mode (mostly in the right hemisphere, that is the dominant one during the first two years of life).
The adult’s “Inside Parent”

- Transition to parenthood evokes the internalized representations of one’s parents’ parenting patterns, the “Inside Parent”, aside the “Inside Baby”.
The motivation for entering psychotherapy is usually distress.

This emotional state is very similar to the one the infant encounters in situations of need where the attachment system is activated.

Much of the transference can be understood in terms of internalized attachment responses, especially in cases of personality disorders.
Countertransference in terms of the concepts of the “Inside Baby” and “Inside Parent”

- The therapist is in a parental role, and his Inside Parent is activated.
- Therapist’s own attachment organization may determine the quality of his “parenting” skills with the patient.
- Still, at times of identification with the patient (usually unconscious, at least at its start), could we say that his “Inside Baby” has been activated, “putting aside” his “Inside Parent”?
Therapeutic moments

- One major therapeutic moment in treatment of severe borderline patients is when the therapist does not fulfill past traumatic expectations of interactional sequences, such as mocking, rejection, abandonment, sexual stimulation, etc..
- By doing so, the therapist perturbed the patient’s internalized system, thus making other interactions possible, with new self- and interactive regulations.
We suggest to conceptualize the therapeutic change as the result of a co-construction that leads to identify the patient’s “clinical Inside baby”, i.e. his distorted expectancies of sequences of reciprocal exchanges.

This process occurs, in parallel to the verbal process, through the therapist’s facilitating awareness of the nonverbal dyadic, moment-to-moment, interactions.
In the name of the Infant who is inside of us, 
THANK YOU 
for having taken me seriously!