CLINICAL PERSPECTIVES

Interview with Dr. Charley Zeanah

(interviewed by Normand Carrey MD, Tulane University, New Orleans, January 9, 2013)

Dr. Charles Zeanah is the Mary K. Sellars-Polchow Chair in Psychiatry, Professor of Clinical Pediatrics and Vice Chair for Child and Adolescent Psychiatry in the Department of Psychiatry and Behavioral Sciences at Tulane University School of Medicine in New Orleans. He is also Executive Director of the Institute for Infant and Early Childhood Mental Health at Tulane. He is the recipient of multiple awards including the Irving Phillips Award for Prevention, (AACAP), the Presidential Citation for Distinguished Research and Leadership in Infant Mental Health (American Orthopsychiatric Association), the Sarah Haley Memorial Award for Clinical Excellence (International Society for Traumatic Stress Studies), the Blanche F. Ittelson Award for Research in Child Psychiatry (APA), and the Serge Lebovici Award for International Contributions in Infant Mental Health (World Association for Infant Mental Health). Dr. Zeanah is a Distinguished Fellow of AACAP, a Distinguished Fellow of the APA and a Board Member of Zero to Three. He is the Editor of *Handbook of Infant Mental Health* (3rd edition) considered as the state of the art textbook and standard reference in the field of Infant Mental Health.

Q. Tell me a bit about your family.

A. I grew up in a family with one younger sister. My dad worked for public relations in a large corporation so we moved around a number of times mostly in the south but also for a while in New England. I grew up always thinking I wanted to be a doctor, even though there were no physicians in my immediate or extended family.

Q. So where do you think the idea came from then?

A. I always thought it was my idea. I think that I wanted to be a doctor even when very young way before my sixth birthday. I think that as a young kid it seemed something my extended family responded favorably to and I am sure that had an impact. These were all people I cared about a lot and thought about a lot. As we got older my sister and I spent a lot of time during the summers with my grandparents in Alabama.

Q. Anything else about your early years that might have influenced you?

A. After graduating from medical school I went on a trip with my dad and we visited one of his high school buddies and he related that my dad, after college had said to him that he was going to get married, have a son and his son was going to be an orthopedic surgeon. So I guess you can say my dad got two out of his three wishes.

The reason my dad said orthopedic surgeon was because in his adolescence he had a lot of serious orthopedic problems and spent a lot of time in hospital and with doctors with less than optimal care as it turned out. One time he spent nine months in hospital in a cast for a pathological fracture. As an adolescent he was quite an athlete and had aspirations to become a professional, but he sustained three fractures playing sports due to an undiagnosed cyst in his right femur. When it was diagnosed doctors irradiated it making things worse, then he needed surgery necessitating a bone resection and graft from his left to right femur, resulting in a noticeable limp afterwards and the end of his sporting aspirations.

Q. And your mom?

A. She was a stay at home mom, very involved with my sister and me. She was always a voracious reader, and I think my early love of reading and books was one of her many gifts to me.

Q. What were some of your later experiences or influences?

A. In college I majored in English lit and that was my pathway into psychiatry although I did not know it at the time. The connection was through tracing individuals' stories over time and looking at the important experiences affecting them. It did not cause my interest in psychiatry but was an early manifestation of my interest in aspects of development.

Q. Any author in particular?

A. I spent a lot of time reading William Faulkner in college and did my honor's thesis on his work. One of the things I was struck by was his ability to tell the same story from different perspectives, different characters relating the

same story, showing how people perceive and experience the same events quite differently.

Q. So when did the idea of pediatrics become more of a motivation in your career?

A. Even before med school I liked kids a lot and I imagined myself being a pediatrician. After my freshmen year I spent a summer with a pediatrician doing general practice. We saw a lot of kids and the visits were very short, convincing me that I did not want general pediatrics so I was looking for a subspecialty.

When I was in med school my mother unfortunately died of breast cancer. Subsequently I became interested in oncology but what interested me more was the psychological aspects of coping with illness.

In my third year, I did an elective in psychiatry, which I enjoyed, although I had never given psychiatry any thought before. In my fourth year during the pediatric rotations we asked for consults from child psychiatry for hospitalized children. I was intrigued, and then I decided to do an elective in child psychiatry. I was fortunate to be exposed to inpatient work, outpatient work and consults – all within a month. That is when I became convinced that child psychiatry was for me.

Q. When did you realize you were interested in infant mental health?

A. After med school I did an internship year in pediatrics, and as part of that I did three months of neonatal intensive care (NICU); there was no question that this experience gave birth to my interest in infant mental health. I was interested in what was happening to these kids and what their long-term outcomes might be. It was clear to me that it was a technologically intense environment, but everyone was under enormous stress and making decisions due to factors other than available objective information.

Subsequently after my internship, I really wanted to understand and make sense of all the feelings stirred up by my NICU experiences. As a second year psychiatry resident I began to go to the NICU weekly to round. Soon, families with babies hospitalized there were referred to me. Then I started to read about prematurity and its effects on development. I was intrigued by the fact that the most important prognostic factor was not the degree of prematurity but family characteristics, that is, the caregiving environment. That had a very profound effect on me.

After general psychiatry, in my child psychiatry fellowship, I continued to be more involved with these premature babies in the NICUs. I trained at a program that had infant research underway. My mentor, Tom Anders, had done pioneering infant sleep research but he was interested in all kinds of things. Stanford had a number of faculty members interested in infant research.

In my fellowship I got involved clinically as someone interested in early childhood and early experiences. Zero to Three, a national organization interested in promoting infant mental health created fellowships by providing money for trainees to design an infant curriculum at their universities but also provided funds to attend a couple of national meetings each year to get exposed to infant mental health experts. In addition to meeting these luminaries, these meetings cemented my identity as an infancy or early childhood person and I began to think of myself that way.

Q. What were the qualities about Dr Anders that made him a good mentor?

A. Tom is an amazing guy. He is smart, passionate, creative, and has great vision regarding big ideas. He also has an incredibly large range of interests. He is one of those people who inspires – who makes you want to be better than you are. He believed in me before I gave him any reason to and stuck with me through a long process of developing an academic career.

Q. Where did your interest in research fit? When did you realize you were good at research?

A. In the beginning it was very difficult for me – I had had no previous research experience. I had a hard time coming up with a manageable research question – coming up with something that had a chance of at least being addressed, if not answered – I struggled a lot with that. Tom Anders and I were talking one day about these very young kids and their parents who had such elaborate attributions, some of them quite negative – how do you get from these very young infants to such extraordinary attributions? Tom thought that this was a great idea for a study. I interviewed pregnant women about their fantasies about their future babies. He suggested a methodology, having mothers complete temperament questionnaires in pregnancy about the baby they imagined – rating the baby's behaviors even before they had met the baby. The women I interviewed were eager and interested. What I learned was that there was a demonstrable stability between mothers' and fathers' perceptions of their unborn baby in the third trimester and the way they perceived the baby after birth. What became clear from this is that parents bring to the relationship expectations and biases about how to interpret their baby's behavior. That launched me into a whole area of initial studies looking at that in particular.

Q. Mary Main was a developmental psychologist and someone who also thought about parental attributes. Did you have any contact with her?

A. I had not even heard of Mary Main but she held her first Adult Attachment Interview (AAI) workshop in 1985 and Tom Anders encouraged me to attend. That training really opened my eyes to the possibility of actually assessing internal representations and paying attention to the narrative quality of parental accounts of their

relationships – something that clinicians had long valued but which had not been systematically assessed. Her great discovery was paying attention to the narrative qualities of how adults described their own relationships as important in predicting their relationships with their child. It really was the AAI that got me into attachment research with infants. Because of the clinical work I was doing, I was seeing a lot of very young kids who had suffered abuse and experienced adversity, and a central focus was observing how this affected the quality of their attachment relationships with caregivers.

Q. Where did you get the idea for the Working Model of the Child Interview?

A. That came from my first independent investigation of parents' prenatal fantasies about their babies that I described a minute ago. In the study, we asked parents to "describe your impressions of your baby's personality now." This was at 34 weeks gestation, at one month and at six months postnatally**.** I was amazed at the elaborate responses they provided, even prenatally. I had begun developing an interview to explore that question in much more detail when I discovered Mary Main's work on narrative qualities and was heavily influenced by that.

Q. Tell me about how you became involved with the Romanian orphans or the Bucharest Early Intervention Project?

A. I had a longstanding interest in disturbed attachment. I was fortunate to be invited to be part of the MacArthur Foundation Research Network on "Early Experience and Brain Development," that was chaired by Chuck Nelson, a cognitive neuroscientist at the University of Minnesota. His colleague was Dana Johnson, a neonatologist who opened the first international adoption clinic in the United States at Minnesota. Dana had made many trips to Romania, and he suggested to Dr Nelson that there might be an opportunity for Network researchers to study children in Romanian orphanages. Chuck was not interested in going to Romania himself, but he said he knew someone who might want to go, and that is how I got involved. I was part of a group of about ten physicians and psychologists who visited institutions in several sites throughout Romania. Initially, we were interested in doing evaluations to see if these kids could be adopted into families and determining what kinds of problems they might have. At the end of the week, we reported our findings to the Romanian Secretary of State for Child Protection, Cristian Tabacaru. He was a committed reformer in Romania, interested in developing alternatives to institutions for abandoned children. He had learned about foster care in France, but it had not even existed during the communist era in Romania. In Bucharest there were only a small number of government-sponsored foster homes – the vast majority of very young children were living in institutions. After I got back to the US, I contacted Secretary Tabacaru and explained that I was part of this research network and that we were interested in an intervention study. I asked if he would he be interested in such a study. He said that he definitely was because of a policy debate within Romania about how best to care for abandoned children. At the fall of Ceausescu there were a large number of kids in institutional care (180,000), and the government was struggling a decade later to find ways to deal with this problem.

Eventually we were able to design a study that became the Bucharest Early Intervention Project, the first RCT comparing foster care to institutionalized care. In order to conduct the study, we first had to create a foster care system in Bucharest. Here, we drew on my experiences working with young children in foster care here in New Orleans.

Q. What was your biggest surprise about this project?

A. Many things, but I am still amazed that we got it launched and were able to sustain it. We are continuing the study there more than 12 years later. We were so fortunate in the early days to have funding from the MacArthur Foundation because this gave us the much needed flexibility to make it work.

Q. What was your biggest shock?

A. It was how the Romanian caretakers in the institutions coped with the fact that they were responsible for such large numbers of kids. They adapted to their situation mostly by maintaining a cool detachment; when it was play-time they talked to each other instead of playing with the kids. During other times, they provided instrumental care rather than being truly invested in the children. I wondered about how they could go home and function and relate in a different way with their own families which I am certain was different than how they were with these kids.

Q. What about the ethics of an RCT with this kind of vulnerable population?

A. The ethics were something we deliberated for years. We sought and received permission to conduct the study from three university IRBs and two ministries within the Romanian government. The basic idea was that after randomization we did not interfere with any child's placement – all decisions were made by governmental authorities. Specifically, no child was maintained in institutional care so that they could be studied. We also used only measures involving minimal risk. No child was refused adoption, regardless of the group he was in. We have published a number of papers specifically relating to the ethics of the project, and there have been several commentaries by bioethicists about the study, generally substantiating its ethical soundness.

Q. What lessons from this project are there for us?

A. One of our central findings was that children abandoned at birth who have all the prenatal risk factors and then placed in a deprived institutional setting and then later placed in more optimal setting can recover significantly but

not completely. Substantial recovery in many developmental domains is possible.

The second major finding is that the timing of the intervention matters. In keeping with the notion of sensitive periods in brain development, the earlier a child was placed in foster care the more likely the child would have a better outcome, though only for some domains of development.

The third major finding is that one of most important mediators of outcomes is the quality of attachment the child forms to their caregiver, which is true in foster care as well as for institutional care. This intervention was really about providing caregiving relationships to deprived young children, but even in institutions the quality of care matters to prevent future psychopathology.

Q. You had a hand in shaping infant psychiatry through your research and through your *Handbook of Infant Mental Health* – What still needs to get done?

A. There was some work in the mid 1980's about how psychopathology in young kids is within relationships rather than within individuals. Relationship specificity in young children refers to the fact that they may express symptoms in one relationship but not in another. As the child gets older and internalizes the conflict and problem, they may manifest problems across a number of settings. I anticipated that more progress would be made in developing ways to describe and define relationship psychopathology. One of the biggest disappointments in my career is that we have made so little progress in this area in describing relationship psychopathology – as Dan Stern said, we have a "one person" not a "two person" psychology.

On the other hand, what is exciting is that neuroscience and cell biology and all these basic fields have gotten very interested in how early experiences affect the developing brain and this work is beginning to elucidate how experiences lead to various outcomes, good and not so good.

Q. What is not necessarily your greatest achievement but the one that gave you most satisfaction?

A. Two things that have engaged me in terms of interest and challenge are 1) the Tulane Infant Team, a collaborative effort between our faculty and trainees and the Department of Child and Family Services. I have been involved with this team for the last 18 years, intervening with young maltreated kids and their families. I find the clinical challenges as difficult and compelling as anything I have experienced in my career. It is interesting because it involves all these other systems, legal, child protection, education, mental health; the young kids and their families are embroiled at the confluence of all these systems that have different languages, values and orientations – that has engaged me a lot. And in parallel, there is the work in Romania, which I have been involved in with Chuck Nelson and Nathan Fox for the past 12 years. This is similarly challenging and compelling in many ways. I often think that in Bucharest I am trying to get kids into foster care, whereas in New Orleans I am trying to get them out of foster care.

Q. At your Infant Mental Health clinic I understand that some staff have been there from the beginning 18 years ago and others have been there for many years. What is your secret for keeping your staff at the clinic for so long?

A. Yes, Julie Larrieu and I have worked on this together from the beginning, and several others have been with us for more than ten years. I think that the work itself, although intense, is engaging and satisfying, and I think that we recognized from the beginning that it is challenging, and we had to rely on one another. Although there are individuals doing their own thing, there is a collective group ownership, so sometimes it's the transportation person or someone else who makes a key observation in the waiting room, so when we get together for case conferences, everyone is listened to and valued for their insights.

Q. An unfair question but what is your favorite paper?

A. When I was in training I was interested in the 1975 paper by Sameroff and Chandler on the transactional model. In the clinical arena, it was definitely Ghosts in the Nursery, by Selma Fraiberg because it informed how you go about interacting and thinking about infants in the context of their families. I was also more than impressed – really quite blown away by – Dan Stern's 1985 book, *The Interpersonal World of the Infant*. I think it is an amazing tour de force because he was able to draw data from obscure and dry experiments and spin a compelling theory of self and development out of it – also this idea that you can use findings from another field.

Q. Dr Alicia Lieberman from University of California at San Francisco is the founder of Child-Parent Psychotherapy, the first type of interactional therapy for the mother-infant dyad based on psychoanalytic and attachment principles; what was her influence on you?

A. I first met Alicia around 1982. We were very junior people attending a small meeting at UCSF where Dan Stern was beginning to elaborate his theory of self development which eventually became the *Interpersonal World of the Infant*. I think we were both pretty spellbound at the meeting, but we began to see one another at this or that professional meeting afterwards, and soon we became close friends and eventually collaborators from afar, with many shared interests. Alicia originally had gone to San Francisco to work with Selma Fraiberg who had developed "Infant Parent Psychotherapy." Alicia mastered the approach, and eventually conducted randomized controlled trials to demonstrate its efficacy. She also extended it to preschool children and their parents, and it became known as Child Parent Psychotherapy. She is a remarkably gifted clinician, researcher and teacher, part of a vanishing breed of true "triple threat" academics.

Q. In the preface to your book "Handbook of Infant Mental Health," you mention how badly needed infant mental health programs are at risk of disappearing because of state budget cuts mostly driven by ideology. What lesson is there for us?

A. When I wrote protesting these cuts several years ago it was prophetic in that it turned out that those are the times we live in now. For four successive years our state budget for mental health has been cut drastically. It underscores for me the importance of translating what we have learned about early experience and its benefits in terms of long-term economic impact. We always thought it made sense that if we deal with problems early in life, then in the long run it would be cost-saving. Now we have solid evidence about that – the challenge now is communicating that to people creating policies and emboldening them to invest for the long term, not just in things that satisfy an immediate need.

Q. Any comment on DSM-5 vs DC-0-3R, the classification system for infants?

A. Despite lots of flack, DSM-5 is moving in the right direction in that it involved a conscious effort to make it more developmental. But revisions in DSM are dependent on research, and many areas do not have the research basis to help us understand developmental manifestation of disorders, so my hope is DSM-5 will spur more research and become increasingly more developmental in future editions.

The DC-0-3R was created because the DSM was clearly not applicable to infants and young children. DC-0-3R has been a major help to clinicians, but it still needs a lot of empirical validation.

Q. When you look back, what keeps you hopeful?

A. I think it is the people I have been privileged to work with over the years. They have maintained patience, commitment, passion and humor. When I began my career, infant mental health was an obscure field with a handful of luminaries and a few dozen people interested in it. Now, it is accepted well beyond academia – even in government agencies – it's been amazing to watch. That gives me great hope.

Q. And finally when do you think the Saints will have another run at the Superbowl?

A. Next year, count on it!!

Thank you Dr. Zeanah.