

Shrink Rap Radio #339 February 19th, 2013

“Infant Research and Neuroscience Implications for Psychotherapy”

Dr. David Van Nuys Ph.D., aka ‘Dr. Dave’ interviews Judith Rustin
(Transcribed from <http://www.shrinkrapradio.com> by Gloria Oelman)

Introduction:

My guest today is psychoanalyst Judith Rustin and we'll be discussing the implications of her work in infant research in neuroscience for psychotherapy. Judith Rustin, LCSW is a faculty member and supervising psychoanalyst at the Institute for the Psychoanalytic Study of Subjectivity in New York City. The psychoanalytic Psychotherapy Study Center, in New York City as well and The Chinese American Psychoanalytic Association. She has lectured nationally and internationally and published scholarly papers on self-psychology, intersubjectivity systems theory and more recently the interface of infant research and neuroscience with these two psychoanalytic theories. Her published scholarly papers cover these same subjects and areas of expertise with particular emphasis on their application to the therapeutic dyad and the clinical process. Prior to becoming a psychoanalyst Judith was an assistant professor, field faculty, at the Columbia University School of Social Work. During that tenure she helped to develop a program that integrated disabled students on a college campus and develop models of programs to ensure permanency planning for children. Currently she maintains her private practice in New York City.

Now here's the interview.

Dr. Dave: Judith Rustin welcome to Shrink Rap Radio.

Judith Rustin: Thank you. I'm glad to be here and glad to be talking with you.

Dr. Dave: Well, I'm very glad to be talking to you because I keep running across your name. I've been doing a lot of neuroscience related interviews and your one of the people who always gets cited so I feel very honored to speak to you. And we're gonna be focusing on your book that just came out – it's a 2013 book – *Infant Research & Neuroscience at Work in Psychotherapy* and at first blush the title of your book *Infant Research and Neuroscience at Work in Psychotherapy* seems like a rather unexpected conjunction of ideas and domains. Tell us about your first glimmer of the interrelationship between these domains.

Judith Rustin: Well, it actually derived from my interest in infant research and applying infant research to clinical practice. The infant research that I began to study and learn about really derives from Daniel Stern, Beatrice Beebe with her collaborators Joe Jaffe and Frank Lachmann and the infant research that they do really focuses on face-to-face play in infant-mother interactions. So I really began to get interested in that as a theory of interaction. What goes on between the infant and the mother, interactively, that really cannot be spoken in words because infants don't yet

have language and infants don't have the capacity for symbolic thinking, which is symbolic thinking having to do with memory. What we usually think of as memory where you recall 'Oh, you know, when I was three months old I cried when my mother went away.' Infants don't have that kind of memory.

Dr. Dave: Right.

Judith Rustin: So I got very interested and yet we know that those very early experiences become templates of self with other that endure throughout the life span.

Dr. Dave: Yes and we'll get into that more – I think we're gonna be talking a little bit more about memory as we go along. Let me ask you what was your purpose in writing this book – who did you have in mind as your audience?

Judith Rustin: Oh, psychodynamic, psychotherapy clinicians – whether working from a dynamic psychotherapy point of view, whether working from a psychoanalytic point of view, whether working from a dance therapy point of view – people who work in a clinical situation and who are interested in interaction between two people and how that interaction has a therapeutic effect and an effect to change things for the better.

Dr. Dave: Yes.

Judith Rustin: It was for all of the above.

Dr. Dave: O.K. now one of the things I really like about your book is its laced liberally with case history stories from your practice. I hope that you can do the same thing here in our discussion. If any case examples or amalgams of cases come to mind, feel free to sprinkle those in at will.

Judith Rustin: I will do my best. The case examples in the book are amalgams. There are usually two or three, sometimes more, people put together so that usually requires a certain kind of amount of tweaking and thought...

Dr. Dave: Sure.

Judith Rustin: ...in terms of usually what comes to mind when I'm speaking extemporaneously are people from my current practice, so I do have to be careful to not, you know, if I can do it quickly and think of an amalgam or think about something from the past, I will do it, or make something up quickly. I can do that too but if it's a little stingy in that regard you'll understand.

Dr. Dave: Yeah, sure, of course you've got to observe confidentiality. Now in the book you talk about your own personal development and movement through psychodynamic therapy starting with ego psychology and then moving into the psychology of Heinz Kohut and self psychology and then later to intersubjectivity theory of Robert Stolorow – is that how you say his name?

Judith Rustin: And collaborators – he has three collaborators – major collaborators, he's done almost all of his work with George Atwood, Bernie Brandchaft, those were

the three people that I studied with and Donna Orange has been a more recent addition to collaborating with him on the theory of intersubjectivity dynamic systems theory.

Dr. Dave: O.K. well I'm not sure that all my listeners are gonna be familiar with those and I'm sure that if you were to go deeply into them would take a long, long time that we're not gonna have. I was least familiar with the intersubjectivity theory so that one you might dwell on a little bit more than the other two but maybe you can take us through those three major epochs in your own theoretical development.

Judith Rustin: O.K. Well, I began my career in the late 1960s and ego psychology was the only show in town in those days. I began as a clinical social worker at the Mont Sinai Hospital here in New York in their adult psychiatry department and most of the attending faculty, who were also the people who trained the residents, were from New York Psychoanalytic Institute and that was the bastion of ego psychology here in New York. And I was very fortunate, it was an enormously rich training environment and we were all allowed to participate in the training that the residents had, we were able to participate as well, so I really became steeped in that tradition.

Dr. Dave: Well, what is ego psychology? I mean it's an elaboration of... somehow goes past Freud's original ideas. How would you characterize the heart of the approach of ego psychology?

Judith Rustin: Well, really I would think about it as the use of the Freudian structural model of the mind – that's what I think is meant by ego psychology. The structural model of the mind where you have three – the ego, the id, the superego all of which are organized around managing of the basic drives.

Dr. Dave: And so then you moved on from there to the self psychology of Heinz Kohut. How is that different – what does that bring to the party that wasn't there before?

Judith Rustin: Well, in the interim when I left Mt Sinai I moved to the Columbia School of Social Work and I was involved primarily in training social work students and it was during that period of time that the shift began to occur. So the Columbia School of Social Work revamped their whole curriculum, from an ego psychological approach to an eco systems approach. In other words, that we're all embedded in a social, cultural, familial system and that is what is influencing one's behavior, development, etcetera and I really became much more involved in teaching and training students from that perspective. When I picked up again doing private clinical work myself it was in the late seventies and that's when Heinz Kohut's ideas about the psychology of the self had really started to take hold and in some ways it was a reaction to the ego psychological approach in that he viewed a primary motivation in life was not one centered around the drives but rather one centered around the development of the self. I don't quite know how to explain the development of the self other than how we experience our selves at any given moment in time and that was the primary motivation that we all have as infants, children etcetera. We're always trying to protect the, our own senses of self so that it has an opportunity to be expressed in life, in the world, in our relationships.

Dr. Dave: O.K. well speaking of relationships, then you move along to the concept of intersubjectivity which became especially key to your clinical work. So tell us about intersubjectivity and how that changed things for you.

Judith Rustin: Well, certainly it was partly an outgrowth of Heinz Kohut's psychology of the self and partly developed in parallel to. It did more of an integration in that the theory itself encapsulated both. It encapsulated both the development of the self or what Stolorow and collaborators called development needs, as well as some of the aspects of ego psychology, namely we're not only are trying to express our most authentic selves and often what stands in the way are internalized relationships that make it difficult for us to do. So that was part of it but I think the thing that... and I've certainly integrated all of that into my thinking but the Atwood, Stolorow, Brandchaft view was that the self, or the person, always exists within a system – within a two person system and it is that system that is the unit of inquiry and study so if you apply it to the patient-therapist dyad what you're always looking at is how am I influencing the patient and how is the patient influencing me and how can we understand how those two things are working with each other.

Dr. Dave: Yes and that made a lot of sense to me. I originally was trained in the psychoanalytic perspective myself and was somewhat rebellious and ended up being very influenced by the humanistic psychology movement and so that whole idea of really focusing on the dynamic relationship between client and therapist from moment to moment. That really resonates strongly with me. So how did you become involved in infant research in the first place?

Judith Rustin: Well, it was all part of my psychoanalytic training when... I first... I actually was first exposed to it before there was any book written about it when Daniel Stern – this again was in the late sixties – he came to a grand rounds. At that point I was at St ? hospital – he came to a grand rounds and he started describing what he was doing in terms of filming infants and mothers and so I got very interested in that because the infant research that I've been interested in, has been the face to face play with infants and mothers and what is done in that kind of research is the infant and the mother are videotaped in a split screen – the infant on one side, the mother on the other side, even though in fact they're face to face but when you look at the video you're looking at one on the left and one on the right and in the process of doing the videotaping it can also be slowed down. So you get what's called microanalysis where you can see what is happening between the two people much faster than the eye can see because you're seeing what you can't see in real time but if you slow it down, you see very tiny incremental movements.

Dr. Dave: And I assume our brain picks up on that even though we're not consciously aware of what we're seeing. I'm skipping ahead a little bit but would that be true?

Judith Rustin: That's exactly right. Sometimes, I wouldn't even say the brain – I would say the brain-body. The brain is part of a whole body and it just one part of it but yes that's exactly right because it's conveyed in different ways. It's not just visual, it's aural, it's what you hear, it's its state, you know, what the mother's state is, what the infant's state is. Is it aroused, or is it dampened down? So the videotape

shows it all and you can see it in the microanalysis and that was how I really got interested in studying this part of infant research.

Dr. Dave: Well I think that's one of the things that makes you really distinctive because I don't think that most psychoanalytic psychotherapists get involved in research at all and I know that there are some who have but in the larger picture I think it's relatively small. Now you write that a, um... oh, I wanted to ask you – in what ways do the ideas in infant research and then the emerging explosion of information coming from neuroscience, how do they relate to one another?

Judith Rustin: Well, I, I... that was how I actually got interested in the neuroscience, I actually got interested in it through the infant research. I mean, I was a convert. I believed it, I believed it informs the theory of interaction between... well between all people but certainly in the more intimate relationships and O.K. the infant doesn't have symbolic capacity until, people put it at different times anywhere between one to three years – so what happens with all of those memories? And that was what really got me interested in the neuroscience part. First I started to study about memory, I learned all about implicit memory and procedural memory and I said 'Oh, there it is, that's how things get encoded.'

Dr. Dave: Now you write that... you became a convert but you write that there's a significant portion of the psychoanalytic community that is either skeptical or that outright rejects the application of neuroscience to clinical practice, arguing that it's reductionist. So tell us a bit about that resistance and how you're personally able to overcome it for yourself.

Judith Rustin: Well it's... you know, it's very much like the infant research and the face to face play. When I first started working, I studied a lot with Beatrice Beebe, I don't do the research myself but I'm very informed by her research – her videotapes. When that first started getting applied to adult psychoanalytic practice, it was the same kind of somewhat dismissive response 'Oh, patients aren't infants and therapists, analysts aren't mothers so, you know, this doesn't apply.' But that has changed dramatically because we're talking more in the eighties that that was a sort of dismissive response. There's been the same response initially to applying neuroscience to psychoanalytic or psychotherapeutic work and it goes something like this: 'You cannot reduce mind to brain and to some degree that's true but mind is embodied and the brain is part of the body, so to try and just dismiss it as reductionistic or irrelevant, doesn't make sense to me. And it has changed, I mean, I started working with this in the mid nineties, I would say and things have really changed a lot. More and more people are interested in this and more and more interested in learning about the brain and neuroscience and how it does inform mind and how we can use it in the clinical endeavor but you know there are still... I mean I hear that a lot, again, about it's reductionistic or it's dangerous and we shouldn't...'

Dr. Dave: Hm – dangerous?

Judith Rustin: ... dangerous. Well I think that comes more from perhaps some of the misuse of neuroscience in advertising. You know, you put somebody in an fMRI machine and their brain lights up and you say 'Oh, see they like my product!' There's a misuse of it but frankly it's like arguing about, you know, which is the real religion

– Catholic or Jewish? Or, you know, which is the real politics – Liberal Progressivism or Conservative Tea Party? I try not to get involved in those conversations.

Dr. Dave: O.K. Now you're pretty clear though that this integration of infant research and neuroscience does not lead you to a specific set of techniques, or psychotherapy, so that there's no sort of neuroscience psychotherapy, rather you – what? If it's not that, how does this inform your practice?

Judith Rustin: Well, first of all the whole idea that mind is embodied, you know, the brain is only one part of the body but mind is... it evolves from a body and the brain is part of that body, so what it has done, is it has made me much more alert to the body and asking questions about it. For example patients often have, they have trouble struggling to describe what they feel about something and I will say 'Well tell me what's going on in your body right now.' And that becomes a pathway for them to describe essentially what their emotional response is. So I can say to them 'Oh, oh, that's what it feels... well, all those things that you're describing, are part of anxiety. It's about the emotion of anxiety.' Or if it doesn't fall into such a category, I will use it metaphorically. So a patient might say 'I'm feeling my arms are getting very ah... I'm very aware of my arms' and you know I'll ask them to describe it a little more fully and so what I might eventually get to is 'Oh, I'm feeling when you describe that, that maybe you're trying to hold back punching something.' So it becomes a pathway and a portal for getting at more... at emotions and at feelings that might be harder for the patient or person to describe. That's the way I use it.

Dr. Dave: Yeah, one thing that comes to mind is that there are quiet a few other approaches to psychotherapy that also focus on the body. There are a whole range of body therapies – there's gestalt therapy which would call particular attention, so it's interesting to hear that that kind of focus, that key insight that you're talking about, really has popped up in other places, in other theoretical approaches as well.

Judith Rustin: I'm sure but I only use it as one dimension – it does not replace the traditional psychodynamic interpretative work. I might go from there to understanding why it's hard for this person to own their angry feelings. In other words then begin an exploration psychodynamically about what in their past experience has made it hard, or what makes it hard for them with me.

Dr. Dave: O.K. Now I gather one of the key areas that infant research sheds light on is the role of self and mutual regulation, that's something that you explore in some detail, perhaps you can give us an overview here.

Judith Rustin: O.K. Again it... first of all let me say to begin with, that self and mutual regulation is the terminology of... that comes from, it's called the dyadic systems model and it's Beebe, Jaffe and Lachmann – that's the way they describe it. There are many other, you know, infant researchers who basically are describing a similar thing but they use different language. So, self and mutual regulation is derived from Beebe, Jaffe and Lachmann and it's really how the system of infant and mother operates, in a bidirectional way. So each person of the dyad has to regulate herself, her own state of arousal – the emotional state and the state of arousal often go hand in hand. Each one has to self regulate and each one is simultaneously trying to

influence the other in order to keep one's self in a state of optimum arousal. In other words, not too much, not too little and you know it's a reciprocal, bidirectional, co-constructed process. In other words, I don't know if I'm explaining it?

Dr. Dave: I think you are and of course and right now you're talking about mother and infant but you also apply that to psychotherapy and the clinical dyad between therapist and client. This would be a good place if you do have a way of illustrating that with a clinical example. I don't know if you do but this might be a good place to throw that in.

Judith Rustin: O.K. So, I'll give you a general idea of how I would do it when sitting with a patient who might be very anxious and agitated and they feel very aroused you know, over aroused, they're very uncomfortable. So they are communicating to me a sense of anxiety, agitation, over arousal – I will respond by trying to dampen myself down. So, and you know, again, you do these things non consciously – you're not always aware of it but then at some point you do become aware of it. I notice that I'm sitting more quietly and my voice drops and it gets slower, so you know I will notice this in myself as I am sitting with a person who is anxious, agitated and over aroused. So, I want to give them space to calm down and I do it by dampening myself down and slowing myself down. So they're influencing me and I'm trying to influence them simultaneously and this all happens out of awareness of both partners, unless as the therapist you try to make yourself aware of it, which I do try to do.

Dr. Dave: Yes. Now speaking of awareness, I'm particularly interested in your observations on memory and of course Freud talked about unconscious memories from childhood influencing our, you know, later life. Concepts of procedural and implicit memory that you referred to earlier, have really fleshed that out haven't they?

Judith Rustin: Yes.

Dr. Dave: And I gather that research supports the idea that the early experiences of infancy lay down memories that can influence us throughout our lifespan, even though we may not be consciously able to access them. So maybe you'd take us a little bit through the various kinds of unconsciousness. You talk about the unconscious and non conscious...

Judith Rustin: Right.

Dr. Dave: ...yeah, take us through that.

Judith Rustin: O.K. so you know when Freud was talking about memories, he was talking about what we now, in the language of what we now know about memory – explicit memory. And this is memory that requires the capacity for symbolic thinking – in other words, you have to be able to symbolize an experience in order to have a conscious memory of it at some point. You know when he talked about repressed memory, he's talking about memory that had been conscious and explicit and then gets repressed. Implicit memory is non conscious – it well, it can be non conscious sometimes it's non conscious, sometimes it has had an explicit form and then is repressed but I tend to leave non conscious memory for those very early memories

that never formed explicitly. They're implicit and they are procedural, meaning they're held in the body. Infants are born with the capacity to remember procedures – procedures meaning 'I do this, mother does that way, I move this way, mother moves that way.' The memory is in the movement, in the procedural... it's actually the basal ganglia that encodes that kind of memory – that's movement memory and there's no explicit conscious memory that recalls those things and I reserve those kinds of implicit procedural and emotional memories – infants also have the capacity for emotional memory, that in certain procedures they don't remember the emotion, they feel the emotion. It's held in the body, so when something is reminiscent of an early template experience you can, as an adult, have an emotional memory that occurred years earlier. I just was, you know, reading an article and I was teaching it about... and this is an analyst who has done a lot of body... you know, she herself had experienced a lot of bodywork, trying to understand what her body, what relational trauma her body held and somehow in that experience she went back and asked her mother and learned that there had been a separation – an unanticipated, unintended separation, for a period of time when she was two weeks old. Well, who would remember that but clearly...

Dr. Dave: Yeah.

Judith Rustin: ...her body remembered that. And then there was another one, you know, of a certain number of months later and clearly those abandonment experiences were held in her body and contributed to a lot of the difficulties she had as an adult. So that's what I mean by emotional memories, or procedural memories, or non conscious memories.

Dr. Dave: Yeah, that's really fascinating and I know a number of body workers of various stripes have had that experience of, in massage or body work, touching a part of the body and suddenly an emotion will come up – the person might start crying. There's a place where, on my back when I'm massaged, where I experience, hm, some kind of hard to describe but some kind of longing, some kind of sadness and it's probably just exactly the kind of thing that you're talking about. Something that goes way back that I don't have specific memories that I can pull up.

Judith Rustin: Right. I have a similar experience with my back. So interesting the experience – my back starts to hurt and I have... and this has been going on, you know, for thirty years, so it's always that my initial response is always the same thing. My initial response is 'I'm not up to the task.' So, I mean if you think about the back, you know, you have to stand up straight and if your back is hurting you either have to sit in a comfortable position... For me it translates into 'I'm not up to the task.'

Dr. Dave: Yes, like 'carrying the world on your shoulders.'

Judith Rustin: Exactly. I have no idea where this comes from in my personal history. I really don't but I have learned to respect it (laughter) that when my back starts to hurt, I know I better be investigating in myself, what it is that I'm afraid of, that I don't feel up to the task.

Dr. Dave: Yes and another thing that came to mind when you were talking about procedural memories, which I think of – and you can tell me if I'm right or wrong

here – of sort of like complete behavioral routines that are somehow encoded and as an older adult who's now having some memory issues, I will find myself – I'll be upstairs and I'll go downstairs to do something, maybe I go downstairs with the intent of taking my vitamin pills out of the cupboard and instead I will find myself looking in the refrigerator or taking out the trash and it's as if some sub routine that was there, some fairly complex chain of behaviors, got triggered while my mind was, you know, while I was gathering wool in my conscious mind going down the stairs and I find myself doing something totally unexpected. Would that be an example of procedural memory?

Judith Rustin: Exactly, you know, it's in that somehow you find yourself in the same place and it triggers... you know, you forgot why you went there but you have the experience of a retrieval cue 'Oh, yeah, you know, here's the refrigerator, good time to eat, or yep, there's the garbage can, take the garbage out.' Yeah, that would be procedural memory and our very earliest memories are all encoded procedurally. We don't remember the experience, we just, for example, with an intrusive looming mother, the baby... you know the mother who looms in and intrudes, so the baby avoids, turns its head away. So that becomes a procedure for an intrusive, looming, annoying person and some people keep it as is, in other words, they literally just turn away or walk away. Other people develop... it becomes transformed, so you might not do something so literally in the face of a looming, intrusive, authoritarian person, instead you might start cracking jokes. In other words you do something to avoid the intrusion – and some people keep it literally. They literally walk away, or they turn away and others find, you know, more transformative, symbolic ways of expressing the same thing.

Dr. Dave: Yeah and I guess these procedural memories or procedural sequences are encoded in a lower level of the brain so that the cortex is not involved in assessing them or planning them and that's why they can kind of get triggered by something that's not necessarily thought out.

Judith Rustin: That's exactly right. These procedures are encoded in the sub cortical parts of the brain.

Dr. Dave: You point out that the infant comes into the world with two major parts of the triune brain, which are called the so called reptilian brain and the limbic or paleo mammalian system but that key parts of the ... this was fascinating to me – key parts of the limbic brain have not developed sufficiently to lay down explicit memories.

Judith Rustin: Right and that's primarily the hippocampal area, you know the part the hippocampal area which is deeply involved in forming explicit memories.

Dr. Dave: And you know you've got a diagram in your brain... a diagram in your book (laughter) of the brain and you know lots of books have those diagrams but for the first time I was really struck, I said 'Wow, that hippocampal area looks really small – it's really tiny!' And yet it plays such an important role in all of our memories.

Judith Rustin: That's exactly right.

Dr. Dave: Wow. I guess it's almost like the gatekeeper of memory.

Judith Rustin: Well, as I understand it, it creates the context and the map, you know, whatever that means. That that's the part of the memory – the context – how, where, when things happen and you need that for explicit memory, 'Oh, yes I remember when I was six years old and my mother went away on the first day of school.' That's the context and so you need that for memory.

Dr. Dave: Yes. I was also struck by the paragraphs in which you describe the infant bond with the primary caregiver and the role of what you call face play and you mentioned face play earlier and the role in creating that bond and attunement between the two. Recall you wrote a fair amount on research about face play.

Judith Rustin: Face to face play, right.

Dr. Dave: Yeah. Can you... is there maybe something that stands out in your memory about that research that you could share with us?

Judith Rustin: Well, it's what I describe before in the micro analysis. It's all done face to face. In other words, the infant comes into the world hard wired to prefer the human face. That is...

Dr. Dave: That's fascinating.

Judith Rustin: Yeah. Not only the human face but I forget where I read this, it may have been in one of Stern's books but any configuration of two dots, two dots parallel and then one almost a triangle in a larger space so you can think about it as the two eyes and the nose in an oval. So infants are preprogrammed to be attracted to the human face.

Dr. Dave: Yeah, I just got a new granddaughter who is one month old and she just locks on the face, she just stares at the face.

Judith Rustin: Aha, and does she find it arous... I mean usually infants find it, you know, quite arousing and that's where the face to face play comes in because it is very arousing for the infant – very stimulating for the infant – to see the caregiver's face and so they then walk away, they lower their eyes, they turn their head, they break the eye to eye contact and it's how the mother responds to the infant's attempt to dampen down the arousal. That's what not only... what creates the bond, is the mother's capacity to be attuned to what the infant needs. And so just a few minutes ago I mentioned the looming mother, so an infant who breaks the gaze for a moment in order to sort of calm down, the intrusive mother will go chasing after the infant, you know, loom in 'Oh, come on baby look at me. Come sweetheart...'

Dr. Dave: Yeah.

Judith Rustin: ...and then the infant becomes more and more and more distressed but the mother doesn't get.... 'Oh, what's the matter?' Because the mother is probably feeling – I mean this is just pure speculation – but you can imagine that the mother might be feeling 'Oh, my baby doesn't like me or my baby is rejecting me

etcetera, etcetera but it's in that interaction that the bond gets established because the baby is not able to regulate itself and needs the primary caregiver as a self regulating other.

Judith Rustin: I was interested – you point out that from the very beginning the infant is able to communicate emotions, for example the emotion of aversion and not just through crying. I mean, most of us think of crying and that's the way that the infant communicates emotion but you talked about research that actually where, in this filming, you could see that if the baby didn't like something, turning its head away was one way to communicate that. Are there other ways that the infant communicates emotion, other kinds of emotions?

Judith Rustin: You mean the turning the head away as expressing aversion?

Dr. Dave: Yeah, yeah.

Judith Rustin: Certainly we've all seen babies go rigid and kick their feet – a protest that they're telling you they don't like something. That certainly... it can be considered aversive, it could be angry, it could be distress. Certainly they express emotion through crying, babies have the repertoire of anger, distress, panic, you know a baby who's wailing is in great distress and maybe some panic and any turning the head away – losing toneness, you know, sometimes babies will just go limp. If they try to turn their... I mean, just taking the example of the looming mother that I mentioned before, baby will try all kinds of strategies – turning away, turning the head the other way, kicking. If nothing works baby can just lose toneness, you know, just lie there flat, sort of a way of thinking about it is playing dead 'Enough!' So they have a real repertoire.

Dr. Dave: That makes me think that that could later turn into maybe sort of a passive aggressive style.

Judith Rustin: It certainly could, you know, I'll just lie here, do what you want.' It certainly could.

Dr. Dave: All this makes me wonder if this research on infants has buttressed attachment theory as developed by Bowlby – are there ways in which the findings of infant research have refined or modified attachment theory?

Judith Rustin: I certainly know Bowlby's attachment theory. I know the broad strokes, I know the different attachment styles. I'm hardly an expert on attachment theory – it's like another paradigm, so I can talk object relations but I don't you know I don't know the ins and outs. All I would say about it is that all of the infant research probably supports Bowlby's attachment styles because it's really about how the infant responds to the caregiver's behavior as a self regulating other. So if anything I would think that it fleshes it out in some way but it is a different paradigm.

Dr. Dave: Yeah, I would think that all of this infant research would do something, either confirm or sharpen some of the ideas, so I'll keep my ear to the ground for information about that.

Judith Rustin: Well, I just read an article, I mean it actually just came out in a journal last year – towards the end of 2012 and it was by Beatrice Beebe and a bunch of her collaborators and it was very interesting in terms of giving... refining the ideas about the D babies – you know those who have a disorganized attachment style – and in videotaping infants and mothers who later, at four months, later at twelve months, show disorganized attachment styles. These infants, the mothers were responding to them in inconsistent ways, so for example, the baby is very distressed and crying and the mother is smiling. She may be trying to calm the baby down but the visual is smiling, so she's giving – whether it's out of her own discomfort, her own disorganized attachment style – but the baby gets a mixed message and one of the things that is coded is those babies do less self touching, in response to the mixed message. Well, self-touching is a self-soothing, comforting strategy and so at twelve months these babies have fewer strategies for managing distress. Well, that's not a good thing. We all need strategies for managing distress and if the template begins at four months where you don't have a strategy, you end up feeling helpless and powerless and powerlessness is one of the primary emotional experiences in relational trauma – the sense of feeling 'There's nothing I can do, I'm just powerless.' So there was a research piece that was just published a few months ago that certainly supports... it gives specific data on one aspect of an attachment style – the disorganized attachment style.

Dr. Dave: Well, thank you for sharing that with us. Do you remember the name of the journal?

Judith Rustin: Yeah, it's Psychoanalytic Dialogues 2012. I don't have the volume in front of me.

Dr. Dave: That's O.K. that'll give somebody, if anybody wants to follow up, that's probably enough of a hint for them to chase it down. In your final chapter you write and I'm quoting "The concepts described in this book do not replace any of the old ways of thinking about or doing therapy. They just provide additional pathways for understanding and intervening in a way that offers additional sources of fluidity and elasticity to the therapeutic relationship and clinical process." And I guess you said something like that earlier. It's something that I've heard from a couple of other people that I've interviewed, kind of got the impression that 'Oh, this is going to change psychotherapy in a major way' but it seems like it's subtler than that. But I wonder if you think that this sort of research that we've been discussing necessitates any changes in the way that psychotherapy is taught?

Judith Rustin: Yeah, I think that all of this information should be taught along with the different theoretical models of psychotherapy. I think, yeah, people should really learn about how to think about the implicit, non-conscious, aspects of therapeutic interaction. Patients speak different languages, some patients speak more with their bodies, some speak more with their emotions, some speak more with words and the first century of psychoanalysis it was all about explicit words – what we think, what we know, what we remember and this is... all of this is just adding a way, for me, of understanding the implicit dimension of what goes on between two people. Much of it goes on out of conscious awareness – you know you're not aware that you're doing it but when it enters your... as it becomes part of your lexicon you really do become

much more aware of it and both how your patients are communicating and how you're communicating with them.

Dr. Dave: Well, I think that's a great summary of much of what we've been talking about here, so Judith Rustin it's been great to speak with you and I want to thank you for being my guest here today on Shrink Rap Radio.

Judith Rustin: Well thank you very much.

WRAP UP:

I trust that you found some stimulation and new information in this interview with Judith Rustin. I highly recommend her book to you. Despite touching on such technical issues as infant research, neuroscience and psychoanalytic theory, it's written with considerable grace. Also, there are a lot more clinical examples in the book than she was able to produce in our relatively brief interview and there was the additional issue that the case examples in the book were actually composites of different clients that she had worked with over the years. That sort of amalgamation is necessary for maintaining confidentiality and is a standard practice among clinical authors. I think it was hard for her to recall all the details of these made up cases and at the same time very difficult to make up new amalgamations on the spot. Believe it or not there's still some major neuroscience authors that I'm hoping to interview in the future. One of them is one that she mentions in her book and that is Antonio Damasio. I had a question for her concerning what she referred to as his somatic marker hypothesis but there was not enough time to get to that question. Another person who I've been hoping to interview is Allan Shaw. I do have an email address for him that I received from one of my contacts at Norton Books but I've received no response to my two inquiries. I do have another one lined up with Ian McGilchrist author of *The Master and His Emissary* and *The Divided Brain And The Search For Meaning* so that should give us all something to look forward to.

Thanks to today's guest, Judith Rustin, for sharing her fascinating work on infant research and neuroscience implications for psychotherapists.