Addressing the Element of Deficit in Children with Autism: Psychotherapy Which Is Both Psychoanalytically and Developmentally Informed

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ABSTRACT

The paper discusses a new approach to the psychotherapy of the child with autism: the developmentally informed use of the psychotherapist's counter-transference to repair the deficits in a particular subgroup of severely autistic children marked more by indifference than by avoidance. The deficits concern social, communicative, play and self-regulation functions. Infant development research has illuminated certain precursors of social/cognitive development, and it is important that therapists tune responses to the appropriate, possibly very early, developmental level at which the child is functioning. Technical problems involved in dealing with the addictive elements in autistic repetitive behaviours are also discussed. Modern developments in psychoanalytic technique have helped, but even these may need supplementing in the treatment of severely impaired children.

KEYWORDS

autism, deficit, infant development research, psychotherapy

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ALEXANDER LURIA, the great Russian neurologist, declared that scientific observation is not merely pure description of separate facts. Its main goal, he said, is to view an event from as many perspectives as possible (cited by J.S. Bruner in Luria, 1987). I wish to examine the tragic 'event' of autism from a triple perspective:

1. Clinical findings arising in an interactional situation during long treatments of the patients themselves, that is, the observation by the psychotherapist of both counter-transference feelings and responses to the behaviour of the autistic child (the observer as the observed) and then the child's response to these responses.
2. Modern developments in psychoanalytic theory and technique which involve less attention to the uncovering of repressed material and more emphasis on the containment (in the interactional here-and-now) of lost parts of the personality.
3. Findings from research in infant development – findings which illuminate the precursors – and the precursors of the precursors – of normal social/emotional/cognitive development.

All three perspectives involve the use of a two-person psychology. I think that the type of information thus gained is vital for treatment, but also that it provides a fuller descriptive psychology of autism than that provided by a one-person psychology. Such an approach involves a study of object relations, in particular of infantile ones, and of the stage of development of emotional communication. None of this implies a comment on initial aetiology.

Just one word, however, about aetiology: cognitivists and psychodynamicists/cognitivists alike now do assume multiple causation of autism (Meltzer, 1975; Rutter, 1983; Tustin, 1981). Here an interactional model may be helpful: a baby boy with mild neurological dysfunction and a limp and flaccid or disorganized approach to life, born to a mother who is not alarmed by her failure to arouse her 'good' or possibly even apathetic baby, may then become even less engaged, evoking therefore even fewer attempts on the part of his mother to invigorate him. And so on. An interactional feedback model applied to the first days and weeks of life – when both nature and nurture are given their proper due, but so too is *the awesome power of an effect to become a cause of itself* – should be a promising area for prospective research into the aetiology of autism. The cognitive and social impairment, at the end of such interacting processes, can be out of all proportion to the original weak heredity or original environment (which may have been inadequately invigorating for that particular type of baby), or even to both. The severity and profundity of the condition of autism has in the past lent itself to strong reactions and powerful but all-too simplistic explanations: Bad brains versus bad mothers. Something so terribly inhuman in a human child seems as if it must have an equally terrible and powerful single aetiology. But it may not.

Wing and Gould's huge study of 35,000 children in Camberwell confirmed that Kanner's original set of three symptoms did continue to form a triad (Kanner, 1944; Wing & Gould, 1979). The three classic features of autism:

1. *Severe social impairment* (there was an important change in wording from Kanner's 'severe autistic aloneness')
2. *Severe communication difficulties*, both verbal and non-verbal

3a. *Absence of imaginative pursuits* including pretend play and
 b. with the substitution of repetitive behaviour

All imply a notion of impairment. Rutter (1983) suggests that all of the symptoms could be accounted for by a cognitive deficit common to all of them. Subsequent attempts by authors such as Frith (1989) and Baron-Cohen (1988) to explain the psychological

features in the cognitive deficit make use of what I dare to suggest is a sort of one-and-a-half-person psychology, which asserts that what autistic children lack is a theory of mind. Their ideas are of great interest, but the half-person that may be missing in their theory concerns everything else that goes into personal relations besides cognition and inferences about other people's states of mind. Hobson (1993) has pointed out that the concept of 'persons' is more fundamental than either the concept of 'bodies' or the concept of 'minds' and argues persuasively that the essence of autism is severe disturbance in intersubjective personal engagement with others.

It may be interesting to look at each of the three major symptoms from a perspective which involves both psychoanalytic object–relations (Klein, 1959) and infant development (Di Cagno, Lazzarini, Rissone, & Randaccio, 1984; Miller, Rustin, M.E., Rustin, M.J., & Shuttleworth, 1989; Stern, 1985). Could the absence of a theory of mind then be conceptualized as the *presence* of a theory of an unmindful or uninteresting person? (There is no aetiological implication here: it is the child's inner representations that are at issue, and I shall use the term *internal object*, rather than *representation*, as the latter may be sometimes taken to imply an exact copy of external figures, whereas the former carries no such implication. Internal objects are thought to be amalgams of both inner and outer factors.)

To take No. 1, the most general symptom: looked at from a purely descriptive one-person psychological and behavioural view, 'severe social impairment' may seem to be the equivalent of Kanner's 'severe autistic aloneness'. Yet 'aloneness' is closer to subjective experience and may open the way to further questions: Does the child feel alone? Are there different ways of being alone? Is something invisible keeping the child company? Is it that he or she does not turn *to* other human beings, or is it that he or she does not feel drawn *by* them?. Is he child *with*drawn or *un*drawn? (One child may seem withdrawn and avoidant; another may seem undrawn and indifferent. This paper is concerned primarily with the latter type of child.) Also, what does it feel like to be *with* the child? And, perhaps most important of all, *under what interpersonal conditions are there variations in this feeling of aloneness or social impairment? Does it vary with changes in the other person's responsiveness to the child, for example?* In a model of the mind which involves a two-person psychology, the mind contains not just a self with particular qualities and orientations and possible deficits; it also contains a relation to, and relationship with, what are called 'internal objects' (Klein, 1959) or 'representational models' (Bowlby, 1988), and these too may contain deficits.

The normal baby is now known to be born hugely precocious socially (Newson, 1977, p. 49). To paraphrase Bion, there is always at birth at least a *preconception* of a living (and thinking) human object or, to quote Trevarthen, of 'live company'. Braten proposes that there are, within the central nervous system of the normal neonate, circuits which specify the immediate co-presence of a 'virtual other'. With experience of the actual other, the sense of other becomes progressively more elaborated. Subjectivity, these authors suggest, is inherently intersubjective, inherently dialogic but experience fills in the outline. Bion's version suggests that without an adequate realization in experience to meet this preconception, an adequate *concept* of this living, thinking human object may not emerge. I would add, however, that the traces of a preconception or of a pre-object may still be detectable in children with autism, and it is on this foundation that the treatment may build (Bion, 1962; Braten, 1987; Trevarthen, 1978).

Before I go on to discuss the three major symptoms, I should point out that most of this paper concerns the treatment of a particular subgroup within the larger group of children with autism: that is, those who seem more undrawn than withdrawn, whose lack of social responsiveness seems to be marked more by deficit and indifference than by aloof or

active avoidance. (There are some overlaps with Lorna Wing's views on subgroups [Wing & Attwood, 1987] and also Sue Reid's [1988], although I am referring to children who are largely indifferent but with severe autism.) The avoidant children, probably similar to Tustin's 'shell-type' children, raise quite different technical problems beautifully explored by her, and I do not discuss these here (Tustin, 1981). To be more precise, however, this paper concerns the element of deficit which may exist even in avoidant children. Many cases are mixed: if a child is avoidant for too long or from too early on, there is terrible developmental delay and deficit in normal functions. Many severely autistic children may have no language at all; worse, they may never have babbled playfully. It may be a real achievement in the therapy when the non-speaking child begins to play with sounds, to make sounds which are more contoured, to begin to engage in what Trevarthen calls the 'pre-music' of 'pre-speech' (Trevarthen & Marwick, 1986). How, therefore, can we reach such a child? How should we talk to such a child? Furthermore, if the child's social/cognitive deficits result in a situation where he or she cannot manage two-tracked thinking, that is, to hold two ideas in his or her mind at once, explanatory interpretations of the kind, 'You are very upset, and perhaps that is because . . .' may be far too complex. (See a discussion of the therapeutic implications of Bruner's research on the development of two-tracked thinking in normal babies in Alvarez [1992].) The therapist's comments may need to be simplified and one-tracked; but there is more to it, as I shall go on to suggest. (Many children with autism, as is well known, also cannot manage the I–You distinction, and it is often better simply to identify a feeling, without bothering to locate it in one person or the other. For example, 'It is upsetting that . . .' instead of 'You are upset.' At their level of impairment, thinking about one thought at a time may be quite enough to ask of them.)

To return to the three symptoms for a moment: No.1, social deficit, may need to be addressed, both in terms of the deficit in the child's sense of self and in his or her lack of sociality, but, second, also in the lack of sociality of his or her 'internal object'. The child may seem uninterested in other people, but may also have failed to build up an inner image of a figure who is interest*ing* or who is interest*ed* in him or her. No. 2, communication difficulties, may require definitions which include a description of what kind of internal listener or responder the child is addressing or failing to address. Why does he or she not speak? Toward whom or what is the child failing to communicate? This will therefore raise questions about the kind of developmental level on which the therapist's communications should function. No. 3 is more complicated, because it contains two elements, the first which I call 3a, the lack of imaginative pursuits and pretend play, which, like symptoms 1 and 2, involves a deficit, so we can wonder about the absence of a playable-with or playful object; but the second element, that which replaces imagination, the terrible symptom of repetitive or stereotyped rituals, may have as much to do with disorder and deviance than with deficit. I call it 3b. It is different from the other symptoms: it defines what the child does, not what the child omits to do. It seems to be an alternative to, some writers suggest a replacement for, normal social and emotional communication (Dawson & Lewy, 1989; Tustin, 1981). In a way, it is more than a substitute for 3a play, it is also a substitute for Nos. 1 and 2, normal social contact and normal communication. Can our felt perceptions in the counter-transference when we *sit for long enough* with such children teach us anything about the rituals? Deficit requires repair, but what do we do about disorder? And what if something more than disorder is involved?

Method of observation

To examine the autistic child while ignoring the interpersonal dimension *between us* may be like listening to music while tone deaf or comparing the scent of two roses without a

sense of smell. The musician buying a new cello insists on playing it first in order to assess its tone and resonances. Hamlet, mocking Guilderstern for imagining he can play *him*, says of himself, 'and there is much music, excellent voice, in this little organ, yet cannot you make it speak'. What is studied is a living changing relationship, a song, not a still life, and a duet, not a solo. If one forgets this, autistic patients have a way of reminding us. Several of my own autistic patients have done certain things *only* when my attention has wandered for a moment, never when my attention has been fully on them. I have had to monitor my responses as well as theirs, and try and remember what I just did and just felt or failed to feel and do. They do not *declare* an interest in us openly but they do find their own methods of *eliciting* interest and even mindful attention. Mark, an 11-year-old, can go on engaging in his repetitive rubbing of the table, walking in circles, rubbing the table, walking in circles again, for half an hour at the far end of the room while my gaze is on him. The moment my mind and my gaze wander away from him, or simply the *quality* of my gaze changes (i.e. a bit absent-minded) his circle changes to an oval which brings him into my field of vision. Thus he gets my attention back! Then and only then does he return to walking in his circle. The signals of the 'undrawn' children are very faint; the signals of the avoidant children are often extremely indirect or delayed. In either case, the therapist may need to use all her or his powers of observation in a highly vigilant manner.

Therapeutic implications of deficit in the internal object

Waking the child to mindfulness and amplifying preconceptions

First example Robbie, another autistic patient, showed behaviour which seemed to be the most un-object-related and asocial I had seen outside the back wards of psychiatric hospitals. Yet it was possible to ask the question: Toward what kind of object or near-object or pre-object was he relating or failing to relate? His own answer when he was eventually able to put it into words was, 'a net with a hole in it'. That of course is not a very human, useful or magnetically attracting object. My endless therapeutic problem was, how was I to become dense enough, substantial enough, condensed enough to provide him with something or someone who could concentrate his mind? Simply waiting receptively and too passively for him, in his infinitely dispersed and flaccid state, would have taken a lifetime. And, in fact, until I belatedly got clearer about my task with him, my first and illest autistic patient, it did.

His own image for what finally got through to him was a kind of lifeline. Robbie was a dreadfully empty and lifeless boy, but one day, soon after his treatment was finally increased from once-monthly treatment to five times weekly at the rather late age of 13, he described how a 'long long long stocking' had been thrown down to him in a dark pit where he said he had been for a very long time. This stocking enabled him and all his loved ones to come out and go 'flying over to the other side of the street'. He himself had always had a rag-doll lost quality and spoken in apathetic little wispy listless phrases, but here he came dramatically, verbally and musically to life. The implications of some kind of lifeline were inescapable. Robbie was socially impaired and indifferent because, I think, he had given up.

There are interesting questions here concerning subtypes: I came to the view that Robbie was not hiding, he was deeply lost. With the more actively withdrawn shell-type children, where there is a self in hiding, we have to be far more careful not to be intrusive, and to respect distances. Every autistic child is different, and is different from one

moment to the next, but concern about intrusiveness would have been something of a luxury at Robbie's terrible level of psychic emptiness.

My function seemed to be to reclaim him as a member of the human family because he no longer knew how to make his own claims. He had stressed the *length* of the rope/stocking. And this exactly corresponded to my continuous feeling that I had to traverse great distances – distances created both by the degree of his unresponsiveness and also by its chronicity: he was a terribly long way off, and he had been there a long time. He needed to be recalled to himself. I chose at the time the word *reclamation* to describe the situation. Wasteland does not ask to be reclaimed, yet its hidden potentiality for growth may flourish nonetheless when it is reclaimed. I had begun to notice that Robbie at times could be awakened to himself and to me when I spoke in particularly lively or urgent tones. (Robbie later often spoke of the time when he had been sent away to the country to strangers at 18 months [when his descent into deepest autism seems to have begun] as the time when he had died.)

The chronicity itself may need to be addressed, long before luxurious questions such as the child's original reasons for having autism, can be dealt with. Neither seeing his unresponsiveness as defensive autistic withdrawal nor seeing it as a passivity resulting from a projection of active ego functions into others seemed appropriate to his level of deficit. It seemed that his internal object was as empty of life as was his sense of self. Perhaps Robbie had a predisposition to autism, and perhaps two early traumas were the final straw. But years of autism bring further consequences in their train. A weak sense of the reality of other people may get weaker, and the child may lose ever more interest. Malnutrition, or a state of starvation, is a condition vastly different from hunger. In thinking about Robbie's lifeline story, I gradually became aware that I was often overwhelmed with powerful counter-transference feelings of urgency about his nearness to psychic death; at other moments it was all too easy to forget about this and peacefully allow my mind to slip away dangerously, just as he had.

Subsequently I had to learn to think about how to translate the original dramatic emergency-rescue operation and the panicky moments of urgency on my part into something more like a steady regime of regular vigilant intensive care which does not panic but must not be too slack. I had noted, early on, that I often found myself moving my head into his line of vision, or calling his name, in response to his rag-doll emptiness. I now think it is possible to respond to the child's needs to be found down his dark pit (or, in the case of other children, to be found in their bland and all too comfortable permanent resting-place) and to be reached, by working on oneself to provide a tighter, tauter and less slack ongoing attention; this need not always involve moving one's head or raising one's voice, but does have something to do with the level of intense attention necessary – perhaps like the primary maternal preoccupation described by Winnicott (1965). In a way, the cognitivists were right to criticize us psychoanalytic therapists for imagining that explanatory interpretations about the past could help such very impaired mindless children. But we have learned that less attention to the past and more to the present, with careful attention to the quality of the relationship in the living here-and-now does seem to bring dividends and to begin to repair the social deficit both in the self and in the internal object.

I now want to examine a possible link between the 'reclaiming' activities directed to desperately ill patients, and the more normal 'claiming' and 'awakening' activities engaged in by ordinary mothers of ordinary babies. Klaus and Kennell (1982) studied parent–infant bonding by filming mothers' and babies' behaviour in the delivery room for 10 minutes during their first contact after the birth. The mothers at first examined every part of their newborn infants. At the same time, they showed intense interest in waking the infants in an attempt to get them to open their eyes, and this was verbalized

by nearly three-quarters of the mothers: 'Open your eyes, oh come on now, open your eyes,' or 'If you open your eyes I'll know you're alive.' After one baby boy in a similar study finally opened his eyes, his mother said, 'Hello!' to him seven times in less than one and a half minutes (Macfarlane, 1977, p. 53). In videos by the developmental researcher Lynne Murray, the voices of normal mothers show an unmistakable note of coaxing or of invitation as in, 'Come on, give us a smile.' (Murray, 1991).

Brazelton and colleagues' study, 'The Origins of Reciprocity', describes what the mother does when she is invited to engage in a period of interaction with her from her 2-to-20-week-old baby son. The things she does in order to engage her baby's attention in the first place are quite different from the things she does after it has been gained, when she is then attempting to sustain it and maintain it. At the first stage she reduces interferences from within and without, by making him comfortable and by containing startle reactions. She moves her head into his line of vision to get eye contact. At the next stages, although avoiding overloading, she nevertheless starts explosively to get his attention, and alerts, amplifies, emphasizes, accelerates her speech and caresses to keep his interest; when his interest flags, she exchanges one activity for another, or alternates alerting with soothing, always improvising. This is 'live company' (Brazelton, Koslowski, & Main, 1974).

I think that there may be lessons to be learned for work with children with attention deficits and communication disorders, where deficit *is also in the internal object*. A more active approach need not therefore imply seducing a passive patient into life when what he or she should have had was help to be able to come alive for himself or herself; rather, it may involve something more like calling an almost comatose patient into life. (I discuss elsewhere the problems when the symptom is overdetermined, where deficit is accompanied by secondary gains, and genuine incapacity and indifference is exploited by passive complacency [1992]. These mixtures and complications are the stuff of clinical work.)

In the Tavistock Autism Workshop we have learned nowadays to be more gently active, to try to get eye contact where we can do so tactfully, maybe even occasionally to 'chase' the child a little, without being too intrusive – finding the right distance, psychologically and physically, is all-important: not too far away to reach him or her but not too close to scare the child off. Most of this sensing of distance, of tone of voice, speed and pitch of speech comes quite naturally to people when they speak to tiny babies. It does not always come so naturally when one is speaking to a 10- or even 4-year-old child who seems to be rejecting or ignoring all our friendly overtures.

I hope it is clear that I am not suggesting that the 'cause' of cognitive deficit or emotional apathy or both in a baby is in the caregiver. But a baby who is born apathetic, or who is drifting away, for whatever reason, from human contact, may have required a tauter pull on the lifeline than would a more vigorous baby. And he or she may not have got it. What I am suggesting is that the *conditions for recovery*, regardless of what combination of factors may have set the child originally on an autistic path, may nevertheless lie in the area of promoting a capacity for interaction *at the appropriate, possibly very early, developmental level.*

Second example I now want to give a second example of an interaction with a 3-year-old autistic girl, Angela, where a seemingly unsocial ritualistic preoccupation with doors did seem to hold the seed of at least a preconception, but not the concept, of a living object. Angela's mother was a single parent and said that when her marriage was breaking up she became very withdrawn from her towards the end of the first year of Angela's life, but that after several months of her own withdrawal, she realized that Angela had

become far more attracted to and obsessed by a ceiling light in the living-room than she was to her. The mother herself seemed very flat and seriously depressed when we first met her. In the first session Angela was very absorbed in opening and closing doors on a doll's house which my colleague Trudy Klauber and I had provided. By the second session, I began to feel sure that her absorption was not as mechanical as it first looked. She appeared to be studying the house through the doors, and I wondered, Was she checking for symmetry or fascinated by three-dimensionality, tunnels or what? She was clearly, in her confused urgency, not getting the answer to her 'question,' so in the end I suddenly thought of peeking back at her through the tiny window on my side of the house. She smiled with delight, and threw herself on her mother as though to celebrate, and this sharing of her joy delighted all three of us adults.

We underlined Angela's wish to share her pleasure with her mother. There are important issues there about how, during an assessment, to test the child's capacity to respond and, at the same time, to help parents to learn how to engage the child better, without making the parent feel responsible for the child's autistic condition. (Chapters by Sue Reid in our book in preparation will discuss the assessment process and the importance of work with the families of the child.) Angela's needs were not being clearly expressed. In this situation the child and parent can fall or drift further and further apart. If Angela was looking for something, she didn't quite know or remember what it was. She was in a state of pre-expectation, rather than expectation. Like Klaus and Kennell's and Brazelton's mothers calling their babies into contact, I think that for a moment I provided a realization of a preconception, not of a concept. I met a pre-need, not a need. The child needs repair to his or her ego defects (Sandler, A.M. & Sandler, J., 1958) but also to the defects in his or her internal objects. Everyone concerned with the child may need to be sensitized to respond to, amplify and focus signals which are weak, delayed or highly immature. In many cases, individual help for the child would not be the treatment of choice, and work with the child in his family is carried out instead.

Communication deficit

Getting on the right developmental wavelength

The preceding examples show how difficult it is to separate the three symptoms out, but let us move on to No. 2. Trevarthen studied 'pre-speech', and 'pre-music' dialogues between mothers and their actively participating babies. Apparently, 'motherese' is high-pitched, initially in an adagio, later in an andante rhythm, and the dialogue has certain rhythms in common in every language (Trevarthen & Marwick, 1986). Can these findings about the nature of early dialogue be of practical use to us clinicians in our understanding and treatment of the autistic child's communication difficulties? Mostly by accident, I have learned to think that they can and that we may need to rethink how we talk to these children in order to repair the communication deficit.

I had a rather strange experience with Mark, the 11-year-old autistic boy with the table-rubbing and walking ritual. I had begun to try to reach him on early rhythmic levels, talking and tapping my feet in time to his ritualistic walking, and he had seemed lit up by this, and began himself to improvise a little, and even to follow my rhythms occasionally. He had become freer and, according to his parents, happier. But the first time I ever spoke in an even freer real 'motherese' happened without plan. I was talking to Mark about the fact that his family was moving out of London and how he would lose his twice-weekly treatment, but that his mother had promised to make the long journey about once a month. It was very painful for me because he had recently become so much more reachable, and for him because he had had a terrible set-back only the Christmas before when

he had lost his previous therapist. I mentioned his coming back after Christmas, and then my notes read 'I seemed to go into this baby talk – the way you talk to babies or animals, and I said, softly and coaxingly "Would you like to do that, eh? Mark???" [i.e. come back to see me after Christmas.] I was looking right at him and he had been listening closely. To my astonishment [because in the year he had never uttered a word to me], he suddenly whispered loudly, looking intently at me, "Yesss."'

A week later (by now he was spending much less time in his rituals), he was holding a little toy rabbit which I had handed him, and he kept repetitively but rather playfully turning it away from him. I had been lending words to the rhythm of the turns, occasionally speaking on his behalf, occasionally on the rabbit's. My notes read, 'I have to keep my voice alive or his activity goes dead and mechanical.' At one point, I spoke for the rabbit whose back was turned from Mark and said, "Oh, *please* look at me . . .!", Mark himself swung around and looked at me, very shyly but profoundly. It was very moving.' He thought the plea came from me, and of course he is a very confused child, with whom it was rather foolish to make the play too complicated, but my mistake taught me something. Trevarthen suggests that the baby's sensitivity to certain rhythms and pitches is innately laid down in his or her brain, and when one sees these children light up and pay attention the moment the voice of a colleague or parent changes to 'motherese', one feels Trevarthen must be right (Trevarthen & Marwick, 1986; also see Riccardo Steiner's [1987] discussion of the work of Ivan Fonagy, an authority on psychophonetics, on the importance of intonation in protocommunication).

Deficit in playfulness

I have already mentioned the way in which the therapist may join in on the child's private and unsocial activities, by tactfully lending accompanying rhythms to something the child is doing. The child with autism may not be ready to become interested in other people, but he or she may be enabled to become interested, first, in *their interest in him or her*. The developmental level has always to be taken into account. The child may not be ready for ball-throwing games or not even be ready for ball-rolling games. The child may, indeed, not even be ready to pass a ball to us, but might, slowly, accept one into his or her hands, and after a few weeks of this, be prepared to offer it back and eventually to play a turn-taking game. He or she may not engage in pretend play with doll families, but might persist in lining the dolls up, and some shred of meaning and immature but powerful sense of agency may accompany the behaviour. We have to approach the child where he or she is and move on from there. It will not help if we see the limited doll play only as an irreparable impairment in pretend play. But it will also not help if we are too neutral or too containing and passive in our approach to his or her severe developmental delay.

I have discussed the treatment of deficit, but not said enough about the treatment of disorder, for example, the way in which autistic children do quite actively get people to behave like 'autistic objects' (Tustin, 1981) by using our arms to help them perform a task, while never apppealing or looking into our faces. If the child is desperate, we would be more likely to fit in with such a demand, but we would gradually try to wean the child off such methods, by not playing in too readily or easily with such demands. We try resisting such pressure, *by showing that we have a face attached to our arm*, and eventually beginning to ask for at least a brief bit of mutual gazing before we grant the request. Clearly, much work with the parents is necessary here too. It is all too easy for everyone, therapists included, to get caught up in fitting in with autistic routines.

The repetitive behaviours

Dawson and Lewy (1989) suggest that autistic children have rituals because they cannot modulate states of arousal and thus fail to habituate; that is, they do not get bored when they should. But Brazelton and colleagues' study of reciprocity might support our clinical view in the Tavistock Autism workshop that children functioning at certain early levels of emotional and cognitive development develop both their capacity for boredom *and* their desire for new experience in the context of a living relationship. At very young or very defective levels, they need much help from another person in learning how to modulate and channel experience. I have learned to be very alert to the moments when the autistic child is bored, even with his or her apparently most preoccupying ritual, because the child will either not know that he or she is bored or at least not be able to do anything about it even if he or she is. The rituals can become very desultory – not frenzied and excited. Sue Reid describes how they get 'stuck', and points out that 'stuckness' is different from the truly perverse use of the ritual. In either case, it is necessary, at moments when we may be discouraging the ritual, to help the child to find new objects of interest and not to leave the child to drift, bereft of the ritual but with no idea of what other thing could possibly take its place. Like Brazelton's normal newborn infant, he or she may need to be helped to get rid of interferences, to be called into and awakened to psychological being and mental aliveness and then gradually to learn that communication or play is not only interesting but sustainably interesting. Other, less mentally impoverished children, who nevertheless get stuck on ritualistic talk, may need to be reminded again and again that they do have other thoughts in their minds, and if only they look around a little, they may find them (Brazelton et al., 1974; Reid, 1988).

At this point it is necessary to turn to the addictive or perverse aspects in the repetitive rituals. Kanner did note that the accompanying ecstatic fervour strongly indicated the presence of masturbatory gratification, but this observation has, to my knowledge, never appeared again in the non-psychoanalytic literature. Perverse or addictive motives do not always accompany the rituals, but most clinicians consider it a more worrying prognostic sign when they do. The understanding of perverse sexual *acts*, or perverse fantasies with perverse content, has a long history in psychoanalysis, but the understanding that perverse fantasies may express themselves more indirectly not through the content but through the *form* of verbal presentation is a relatively recent formulation (see Joseph's observations of 'chuntering', 1982; Meltzer, 1973; Tustin, 1981). It was a long while before I learned to trust my counter-transference feelings of terrible boredom and impatience, and, also at times, deep disgust and, therefore, to understand that although Robbie, the first patient, had given up his touching and walking rituals, the repetitiveness had by now invaded his speech – and in a very particular manner in adolescence. His verbal preoccupations had become addictive, but also at times clearly sexually exciting to him, although their content was not sexual. At first he bathed in these verbal thrills and frenzies by himself, but as he improved and became more interested in other people and to possess more will, agency and capacity to provoke, he was more concerned to get others to engage in what to them were simply boring conversations, but to him were crazily exciting exchanges. I had to learn not to repeat certain phrases of his and to make myself put things in a fresh way. (Such work demands constant supervision of one's own autistic laziness of mind.) I also found that I never got away with the least trace of self-congratulatory eagerness in my voice – when, for example, I thought we were really on the edge of understanding something. That, too, would send him over the top. I had to make very firm interpretations as soon as he started to get excited, or I would lose him.

With the younger less verbal children, we tend to try to discourage the rituals,

sometimes by coaxing, sometimes by a firmer discussion of the devastating consequences for their minds. Strangely enough, they seem to understand – perhaps sometimes it is only the concern or alarm in our intonation. Of course, if the child has recently begun to use his or her rituals in order to annoy and provoke people, this is a very object-related and communicative use of the rituals, and a very different matter. It may not be friendly, but it is certainly socially related. We would of course not try and discourage this; it would be more important to let the child know that we understood what he or she was doing and that he or she wanted us to react strongly – that is, that we got the message. A negative message in some of these children is better than no message at all.

It is also important to show such children, at a later point when they finally begin to give up the rituals, that we understand that they are trying to please us, no longer simply trying to excite or annoy us; also, we must note the occasional moments when they enjoy relating to us in an ordinary way. And, just as it may be important to show them when they have clearly sensed our distaste for the frenzied repetitive talk, it is also vital to show them when they seem to have noticed that we like them much better when they make an effort to speak to us in a straightforward way. Often, parents, teachers and therapists are so relieved when the repetitive behaviours diminish, that they forget to capitalize on such moments, and the child can easily slip back. One has to offer an equally magnetic and powerful, but alive, alternative.

Arousal and self-regulation

There is another major deficit which requires attention in the psychotherapy of autism: the whole range of problems connected with the child's difficulty in modulating excitement, and here I refer to excitement which is not perverse, but nonetheless overwhelming (Dawson & Lewy, 1989). It is important to help the children to develop more normal, less autistic methods both of avoiding being overloaded and of cooling down emotionally when overloading does take place. The children may not be turning away from contact because they prefer autism: one boy patient of mine had finally become interested in eye contact, but, just like a 1-week-old infant, could not handle it for too long and suddenly retreated to apparent autism at such moments. I began to realize that he had not left me fully; he had turned away in order to cool down. At other moments, the child may not be able even to use autistic methods to cool down and to stop what is for him or her a too intense interchange. The therapist's own fatigue may sensitize her or him to feelings in the child which the child does not yet know how to recognize and use in himself or herself. This may help the therapist prevent the child going into a mental spin.

Conclusion

The work described here may seem a long way from the classical description of psychoanalysis as the analysis of transference and resistance and its accompanying technical rule of abstinence. But psychoanalysis itself has moved a long way. I cannot go in detail into the developments in psychoanalytic technique, theory and meta-theory, which are important for the work of the contemporary child psychotherapist. These include: less emphasis on interpretations which invoke the past as an explainer of behaviour and more attention to the patient's need and functioning in the here-and-now; the supplementing of the theory of sexuality with a greater attention to, and respect for, the 'higher' side of human nature; the development of a meta-theory that is more relational, less reductionistic and mechanistic and more able to accommodate novelty, growth, change, and the mentalness of mind; and, finally, the supplementing, in the theory of the therapeutic

action of psychoanalysis, of the lifting of repressive barriers with a process which involves, by means of analytic containment, the extending of the boundaries of the self to include the regaining of lost, split-off and projected parts of the self. In the case of the highly impaired children described here, these lost parts of the personality may be under- or un-developed, and this raises problems which may at moments take the therapist beyond even these more modern psychoanalytic advances.

At moments when the child's lack of social responsiveness is arising from massive deficit in both ego and internal object, rather than from active avoidance, when his or her introjective and projective processes function weakly and inadequately and, furthermore, when he or she has little or no language, then interventions must reach the child in a 'language' or form that is appropriate to the (possibly very early) developmental level at which he or she is functioning. At other moments, when the child is more present and aware, and his or her behaviour has more intentionality and motive, more ordinary psychotherapeutic work may take place. I would maintain that this work remains both developmentally and psychoanalytically informed: getting a balance between, on the one hand, attempts to focus and engage the child, to turn preconceptions into concepts, by being developmentally attuned and therefore more active, and, on the other hand, leaving the child space to have his or her own experience once the child is enough *in himself or herself* to be able to do this, is a perpetually difficult task. It is by no means simply a question of playing with the child.

Appendix

When mothers are invited to engage in a period of interaction with their month-old-babies, the sensitive mother (not the bombarding or depressed ones) seems to offer five kinds of experience: First (1) she **reduces interfering activity** by seeing that the baby's physical and psychological needs are met and that his or her reflex startle behaviour has been contained. (Are there any lessons here for dealing with the autistic child's fragmentation and interfering stereotypies?) (2) Then she **sets the stage** by adjusting his or her body to face her and moving her head into the baby's line of vision (!) and making facial gestures to attract the baby's attention. She pats the baby with a rhythm and an intensity which *both alerts and soothes*. (3) She then **creates an expectancy for interaction**, for example, her voice and gestures and pattings may start off explosively to attract the baby but are quickly modulated when his or her attention is caught. (4) **To intensify the baby's attention** there is much improvisation, alternation and adding on of behaviours to accelerate the interaction. (5) Finally there is **allowing for reciprocity** and allowing the baby to turn away and to digest and recover from the experience (Brazelton et al., 1974, p. 65).

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