Therapeutic Approaches to Deficit Elements in Autism: An Interactional Framework Combining Psychoanalytic and Developmental Perspectives

The renowned neurologist Alexander Luria emphasized that scientific observation transcends mere factual description, striving instead to examine phenomena from multiple vantage points (Luria, 1987). This paper explores autism through an interactional lens, examining both the therapist's counter-transference reactions to autistic behaviors and the child's subsequent responses to these therapeutic reactions.

This approach yields crucial treatment information while offering a more comprehensive psychological understanding of autism than traditional single-person frameworks. The focus centers on object relations (particularly early interpersonal connections) and developmental stages of emotional communication, without necessarily addressing initial causation.

Core Autistic Characteristics Reconsidered

Autism traditionally presents three fundamental features:

1. **Profound social disconnection** (evolved from Kanner's original "autistic aloneness")
2. **Comprehensive communication barriers** spanning both verbal and non-verbal domains
3. **(a)** Absence of creative and pretend play activities, **(b)** replaced by repetitive behavioral patterns

These characteristics inherently suggest impairment. Rutter (1983) proposed that a shared cognitive deficit could explain all symptoms. While such cognitive and arousal-based explanations offer insights, they remain grounded in single-person psychological frameworks.

Later theoretical developments by researchers like Frith and Baron-Cohen (1988), explaining psychological features through "theory of mind" deficits, achieve what might be termed one-and-a-half-person psychology - purely cognitive approaches that exclude emotional and communicative elements. (Hobson's preference for "theory of person" proves more apt.)

At the Tavistock, Sue Reid and I conceptualized the condition as "impairment of normal emotionally-based curiosity about and desire for interpersonal relationships" (Alvarez and Reid, 1999). This formulation extends beyond strictly cognitive impairment, incorporating emotional elements like curiosity and desire.

Since curiosity requires an object and desire seeks someone or something, we must consider the nature of such imagined others. Examining the three major symptoms through two-person psychology proves illuminating. The absence of theory of mind might represent the presence of theories about unmindful or mindless, therefore uninteresting, minds.

Reframing Social Disconnection

The most general symptom, when viewed through purely descriptive behavioral psychology, appears equivalent to Kanner's "severe autistic aloneness." However, "aloneness" relates more closely to subjective experience and opens pathways to deeper inquiry:

- Do different forms of aloneness exist?
- Does something invisible provide companionship to the child?
- Does the child fail to turn toward others, or do others fail to draw the child?
- Is the child withdrawn or simply undrawn?

Equally important: what does being with such a child feel like? Most crucially, under what interpersonal conditions does this aloneness or social impairment vary? Does it fluctuate with changes in another person's responsiveness?

Self-focused symptomatology requires supplementation through attention to the child's internal (imagined) other. Two-person psychological models recognize that minds contain not merely selves with particular qualities and potential deficits, but also relationships with "internal objects" (Klein, 1936) or "representational models" (Bowlby, 1988) - which may themselves contain deficits.

Two-Person Psychology Applied to Core Symptoms

Revisiting the three symptoms:

Social deficit requires addressing both the child's impaired self-sense and sociality, plus the lack of sociality in their "internal object" - their image of others, their theory of mindful minds. Beyond appearing uninterested in people, they may have failed to construct inner images of figures who are interesting or interested in them.

Communication difficulties need definitions including descriptions of what kind of internal listener or responder the child addresses or fails to address. They may not expect us to be interesting, raising questions about appropriate developmental levels for therapeutic communication.

The third symptom contains two elements. First (**3A**): lack of imaginative pursuits and pretend play, involving deficit - we wonder about absent playable-with or playful objects. Second (**3B**): what replaces imagination - repetitive or stereotyped rituals - clearly involves disorder and deviance rather than deficit.

Can counter-transference perceptions when sitting with such children teach us about rituals? Deficit requires repair, but how do we address disorder? What if more than disorder is involved?

Observational Methodology

Psychology discusses biological, cognitive, and behavioral explanation levels, but what about personal, interpersonal, intrapersonal, and internal object representation levels?

Examining autistic children while ignoring interpersonal dimensions between us resembles listening to music while tone-deaf or comparing rose scents without smell. Musicians buying cellos insist on playing them first to assess tone and resonance.

We must study not only children's transference responses to us, but our counter-transference responses to them, then their responses to our responses. Responses emerge within relational contexts and sequential changes. We study living, changing relationships - songs rather than still-lifes, duets rather than solos.

Autistic patients remind us when we forget this. Several of my patients perform certain behaviors only when my attention wanders, never when fully focused on them. I must monitor my responses alongside theirs, remembering what I just did, felt, or failed to feel and do. They don't openly declare interest in us but develop methods for eliciting interest and mindful attention.

Clinical Illustration: Mark

Mark, age 11, would engage in repetitive table-rubbing and circular walking for thirty minutes at the room's far end while I watched. The moment my mind or gaze wandered, or simply the quality of my attention changed (becoming absent-minded), his circle became an oval bringing him into my visual field, recapturing my attention. Only then would he return to circular walking.

Therapeutic Information from Observational Methods

Personal History with Robbie (1970s-80s)

Explanatory interpretations proved ineffective. At times, active urgent reclamation became necessary: when he approached his worst states, risking psychic death, I found myself urgently calling his name. Gradually, this lifeline evolved from emergency rescue to steady intensive care - neither panicked nor too slack.

We must address chronicity even in three-year-olds. Without mental life, growth ceases. Robbie described being "down a dark pit," though sometimes hidden places feel cozy and comfortable. If too comfortable, this also kills development.

Another patient, Joseph, arrived in a loving mood and made toy animals kiss tenderly. But it continued endlessly. I found myself thinking that even Anthony and Cleopatra must have occasionally walked in fresh air and had coffee.

Toward what kind of no-object was Robbie relating or failing to relate? His eventual verbal answer: "a net with a hole in it." Hardly a human, useful, or magnetically attractive object. My endless therapeutic challenge: how to become dense, substantial, condensed enough to provide something or someone who could concentrate his mind? Simply waiting receptively and passively for him in his infinitely dispersed state would have taken lifetimes.

Mental starvation differs from mental hunger. Considering his lifeline story, I gradually recognized being overwhelmed with powerful counter-transference urgency feelings about his nearness to psychic death; at other moments it became too easy to forget this and

peacefully allow my mind to slip away dangerously, just as his had. Very intense attention levels prove necessary (perhaps like Winnicott's primary maternal preoccupation, 1965).

Autism researchers correctly criticized psychoanalytic therapists for imagining that explanatory interpretations about the past could help such severely impaired, mindless children. But we've learned that sometimes intensified techniques of coaxing and active but friendly ritual discouragement bring dividends and begin repairing social deficits in both self and internal object (Alvarez, 2010).

Arousal State Modulation

Dawson and Lewy (1989) suggest autistic children have rituals because they cannot modulate arousal states and fail to habituate - they don't get bored when they should. But Brazelton's (1974) study of how mothers amplify, alert, and especially alternate alerting with soothing - how they improvise to catch and hold neonatal attention - might help us find ways to interest these children in novelty and awaken their desire for new experiences within living (emotional, not purely cognitive) relationships.

At very young or delayed levels, they need considerable help from others learning to modulate and channel experience. I've learned to be alert to moments when autistic children are bored, even with apparently preoccupying rituals, because they either don't know they're bored or can't do anything about it.

It's necessary to help children find new objects of interest rather than leaving them drifting, bereft of ritual but with no idea what could possibly take its place. Like Brazelton's normal newborns, they may need help eliminating interferences, being called into and awakened to psychological being and mental aliveness, then gradually learning that communication is not only interesting but sustainably so.

I'm not suggesting that cognitive deficit or emotional withdrawal causes in babies necessarily lie with mothers. But babies born apathetic or drifting away from human contact for any reason may have required tauter lifeline pulls than more vigorous babies. And they may not have received it.

What I suggest is that recovery conditions, regardless of what factors originally set children on autistic paths, may nevertheless lie in promoting interaction capacity at appropriate, possibly very early, developmental levels.

Therapeutic Implications of Internal Object Deficit

Addressing Internal Object Social Deficit

Normal babies are now known to be born hugely socially precocious (Newson, 1980: 49). To paraphrase Bion, there's always at least a preconception of living (and thinking) human objects or, quoting Trevarthen, of "live company" (Trevarthen, 1978). But "preconceptions" may still be detectable even in autistic children, and treatment may build on this foundation (Bion, 1962).

How do we become interesting to these children? How should we speak to non-listening children? How should we (and parents) learn to play with them?

Clinical Illustration: Angela

I want to provide an interaction example with Angela, a 3-year-old autistic girl, where seemingly unsocial ritualistic door preoccupation seemed to hold seeds of at least preconception, but not concept, of living objects (I prefer "proto-conception").

After several months of her mother's depression and withdrawal, she realized Angela had become far more attracted to and obsessed by a living room ceiling light than to her. In the first session, Angela was very absorbed in opening and closing dollhouse doors we had provided.

By the second session, I felt sure her absorption wasn't as mechanical as it first appeared. She seemed to be studying the house through 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 I suddenly thought of peeking back at her through the tiny window on my side of the house.

She seemed delighted and smiled with the strange forced eye-squeezing we'd seen before. She then threw herself on her mother as if celebrating, and this joy-sharing delighted all three adults. I underlined her wish to share pleasure with her mother.

Interesting problems exist about engaging children and helping mothers learn better engagement without making them too envious or guilty that in their own deep depression states they may not have been able to synchronize their responsiveness so exactly to children's needs. Certainly Angela's needs weren't being clearly expressed. In this situation, the two can fall or drift further apart.

If Angela was looking for something, she didn't quite know or remember what. She was in pre-expectation rather than expectation states. Like Klaus and Kennell's (1982) and Brazelton's (1974) mothers calling babies into contact, I think I provided preconception realization, not concept realization. I met a pre-need, not a need.

Communication Deficit and Internal Object Deficit

I've been discussing mainly problems of addressing self and internal object deficits. It's difficult to separate the three symptoms. But moving to Number 2: Trevarthen has studied "pre-speech" and "pre-music" dialogues between mothers and their actively participating babies. Apparently, "motherese" is high-pitched, initially in adagio, later in andante rhythm, and dialogue has certain rhythms common in every language (Trevarthen and Marwick, 1986).

Can these early dialogue nature findings be of practical use to us clinicians in understanding and treating autistic children's communication difficulties? Mostly by accident, I've learned to think they can.

We may need to rethink how we talk to these children to repair communication deficits. I had a rather strange experience with Mark, an 11-year-old autistic boy with table-rubbing and walking rituals. I had begun trying 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, begun to improvise himself a little, and even occasionally follow my rhythms. He had become freer and, according to his parents, happier.

I'm not sure what had happened to his theory of mind, but he seemed to be enriching his theory of feet's communicative and playful potential! But back to speech. The first time I ever spoke in even freer real "motherese" happened without plan. I was talking to Mark about his family 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 monthly.

It was very painful for me because he had recently become so much more reachable, and for him because he had had a terrible setback 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). (The "eh?" is part of my Canadian "motherese") I was looking right at him and he had been listening closely. To my absolute 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 rituals) he was holding a little toy rabbit 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 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 was a very confused child, with whom it was rather foolish to make the play too complicated, but my mistake may have taught me something. It gave me a little more confidence the next time something like that happened with another patient: I did think to myself, "I have been working to make contact with these children for thirty years, and I never thought to say 'please'!"

Normal Playfulness Deficit - Developmental Thinking's Importance

Samuel was a severely autistic child who never looked at any object more than fleetingly. Finally began to be interested in a little blue brick, then in two identical ones. He was dying to look at the two together, but seemed not to know how, and would explode them into the air in terrible frustration. I wondered if he had ever learned to scan, which most babies can do by 3-4 months.

Finally he began to look at my face, but it disturbed him. And I had to help him to slow down so that it could be both safe and pleasurable to look at objects, or even to begin to look at two in sequence. As he began to place rings on a pillar, my suspenseful use of the word "AND" - that is, "now the purple one, and the green one, and the yellow one" - seems to help. Here we

have to address the problem of extending the child's attention span, modulating excitement, but not being too soothing or boring either.

Disorder, Repetitive Behaviors and Sensuality: Traffic Policeman Approach

I have discussed deficit treatment but haven't had time to explore disorder treatment, e.g. the way autistic children actively get people to behave like "autistic objects" (Tustin, 1981) by using our arms to help them perform tasks while never appealing or looking into our faces. If children are desperate, we would be more likely to fit in with such demands, but we would gradually try to wean children off such methods by not playing in too readily or easily with such demands. We try resisting such pressure, except when children seem desperate.

Whenever we might want to discourage activities that have become anti-developmental because children are too stuck, we may do so, but it would be necessary to offer not just deprivation of that activity, which may leave children feeling very lost, but to offer third options in their place. For example, if we have decided not to allow children to sit on our lap any longer, we might need to offer little chairs very close to us and encourage little chats together.

We cannot begin to "teach" children until they have joined the human race by becoming socially engaged, at whatever developmental level is appropriate. At certain stages, it might indeed be the lap. This is more than encouraging theory of mind. If theory of mind precursors are pretend play and shared attention, it's important to understand that these two precursors are social/emotional activities. And the precursors of those lead by definition to two-, or even three-person psychology. Babies learn to play and to share attention in relationships with caregivers.

I should mention that I have not discussed another major deficit requiring attention in autism psychotherapy: the whole range of problems connected with children's difficulty in modulating excitement, and here I refer to excitement that is not perverse but nonetheless overwhelming. It is fascinating to observe and facilitate children in psychotherapy developing more normal, less autistic methods of both avoiding being overloaded and of cooling down emotionally when overloading does take place. They need much help in finding private rest space without having to turn to autism for it.

The therapist's own fatigue may sensitize her to feelings in children that they do not yet know how to recognize in themselves. I have also not discussed the whole range of more usual therapeutic functions such as containment, or more symbolic level or explanatory interpretative work, which is appropriate whenever children are functioning in less impaired states. Children may shift back and forth from moment to moment, but in this paper I wished to address the issue of deficit in children where this is a major characteristic.

Summary

I have discussed the use of psychotherapist counter-transference to repair deficits in self and internal object of a particular autistic children sub-group: deficits concerned social, communicative, play and self-regulation functions, and I have stressed the importance of

therapist tuning responses to appropriate, possibly very early, developmental levels at which children are functioning. I have also touched on a few technical problems involved in dealing with perverse and addictive elements in autistic rituals.

Appendix: Maternal Interaction Patterns

When mothers are invited to engage in interaction periods with their month-old babies, sensitive mothers (not bombarding or depressed ones) seem to offer five kinds of experience:

1. **She reduces interfering activity** by seeing that the baby's physical and psychological needs are met and that reflex startle behavior has been contained. (Are there lessons here for dealing with autistic children's fragmentation and interfering stereotypies?)
2. **Then she sets the stage** by adjusting the baby's body to face her and moving her head into the baby's line of vision and making facial gestures to attract attention. She pats with rhythm and intensity that both alerts and soothes.
3. **She then creates interaction expectancy** e.g. her voice and gestures and pattings may start off explosively to attract but are quickly modulated when attention is caught.
4. **To intensify attention** there is much improvisation, alternation and adding on of behaviors to accelerate interaction.
5. **Finally there is allowing for reciprocity** and allowing babies to turn away and to digest and recover from experience (Brazelton, 1974: 65).

Bibliography would follow with the same references as the original paper

Alvarez, Anne (1996): Addressing the Element of Deficit in Children with Autism: Psychotherapy which is Both Psychoanalytically and Developmentally Informed. *Clinical Child Psychology and Psychiatry.*