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Maria Tselika & Lida Anagnostaki

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Finding meaning, making links, creating space: an early intervention with children on the autistic spectrum and their families

Maria Tselika^a and Lida Anagnostaki^b

^aHellenic Association of Child and Adolescent Psychoanalytic Psychotherapy, Athens, Greece;

^bDepartment of Early Childhood Education, National and Kapodistrian University of Athens, Athens, Greece

ABSTRACT

A novel psychoanalytic intervention with young children on the autistic spectrum is presented, addressing the family as a whole and focusing on the relationships between the family members. The intervention is based on the philosophy of the Tavistock Clinic's 'Under Fives Counselling Service', taking into account the principles of psychoanalytic observation as introduced by Esther Bick, and the tenets which Didier Houzel put forward regarding the work with parents of autistic children. In the paper, the therapeutic journey of young Jason and his family is depicted. The therapists' primary objective was to establish a cohesive narrative of the story of the family as a whole, and of each member separately. This effort implied, first of all, that their story would become an object of thought. Based on the clinical material presented, it is argued that this type of psychoanalytic intervention offered the family the necessary psychic space to process their fragmented story, to contain life-threatening anxieties and to gradually change their way of functioning and relating to one another.

KEYWORDS

Psychoanalytic intervention; autistic spectrum; early intervention; family work; psychoanalytic observation; under-5s work

Introduction

In this paper, our psychotherapeutic journey with a three and a half-year-old autistic boy, whom we shall call Jason, and his family is presented, aiming to put forward a coherent narrative of our work together. Presenting such a coherent narrative has been a demanding task, for at first it seemed to us that the family's own narrative lacked in continuity and contiguity. In the course of this treatment, we, the therapists, were the ones who strived to 'weave together' the fragmented psychic functions of the family members, trying to contain the anxiety provoked by life-threatening phantasies and projections, and gradually, helping to transform the confusion that prevailed in the everyday life of the family, and in the therapy room, into some kind of meaningful communication.

Through the narration of young Jason's psychotherapy, we aim to present a novel intervention with young children on the autistic spectrum, focusing on a psychoanalytic understanding of autism. The work involves the family as a whole and the relationships between family members. One of the main axes of this type of work is psychoanalytic observation (Bick, 1964), and the making of links based on what goes on in the 'here

and now' of the session with regard to the whole family and each member separately. This work aims at attributing meaning to primitive emotional states, which are experienced as 'meaningless' (Rustin, 1989), providing a containing space where thoughts can become thinkable (Alvarez, 1992), and where distress can be tolerable (Rustin, 1989). Interpretation is not the main element of such a psychoanalytic intervention, although many hypotheses are formed in the therapist's mind.

Research on autistic spectrum disorders is currently active across several domains in the human sciences, with a variety of focal points: biochemical, behavioural, developmental, as well as psychoanalytic. Nonetheless, it remains unclear what comes from neurology and what comes from psychology. Autistic spectrum disorders seem to have a multifactorial aetiology and, in this sense, it may be more accurate to speak of 'autisms', rather than 'autism' (Rhode, 2018). Psychoanalytic clinical observation and research with autistic children and their families (for example see Di Cagno, Lazzarini, Rissone, & Randaccio, 1984; Houzel, 1999, 2010; Houzel & Rhode, 2006; Miller, Rustin, & Shuttleworth, 1989; Murray, 1991; Rhode, 2018) converge on the importance of the employment of psychoanalytic therapy in transforming the vicious cycles of impairment and lack of communication into benign ones. If psychoanalytic treatment of children on the autistic spectrum can be successful, it does not necessarily follow that the original condition has no biological origin. After all, as Tustin (1981) has already argued, organic handicap could prevent the child from making adequate use of early nurturing, with pathological autistic compensations coming into play. Such organic factors, combined with neurological impairment, may result in the child being grossly out of touch with reality. Psychoanalytic outcome research provides evidence concerning the interpersonal and intrapersonal psychological elements that can eventually emerge at a secondary, tertiary or much later stage, forming part of an interacting chain of causality, taking the child down an autistic path (Alvarez, 1992).

Despite all the yet unknown aspects of the specific disorder, efficient adaptations in the setting and technique of psychoanalytic work with patients on the autistic spectrum have been put forward. For instance, the therapeutic attitude of the psychoanalytic psychotherapist is the focus of many relevant studies and theoretical formulations. Alvarez in 'Live Company' (1992) discusses neutrality, a main feature of the traditional psychoanalytic psychotherapeutic setting. She wonders how she is 'to become dense enough, substantial enough, condensed enough' (p. 191) to provide autistic patients with something or someone upon whom they could focus their mind, and argues that passively waiting for the patient to get out of their autistic shell would simply take a life-time. Tustin, who has extensively studied the close relationship between autism and psychosis, warns that much individual psychotherapy with psychotic children has been too permissive and too passive (1981). Reid (1990) takes a similar view. Barrows (1988) also agrees that it is beneficial for the therapy's progress if the therapist actively intervenes to draw a child out of his autistic shell. All, however, argue that the adoption of a more active stance has to be carried out with restraint, skill and sensitivity. Based on these formulations, in the method of intervention presented, there are two therapists working with each family, whose stance is more active than in traditional psychoanalytic psychotherapy.

The intervention presented here took place in a Day Care Centre for Children with Autistic Spectrum Disorders, where Jason had been admitted as an out-patient.

The Day Care Centre offered three classes for children aged from three to ten years. Jason would follow the daily routine and activities of his class; however, once a week his parents and his younger sister, Daphne (later on, his newborn brother, as well) would come to the Day Care Centre and would all together attend psychotherapeutic sessions with two psychoanalytic child and adolescent psychotherapists trained in the provision of such therapeutic interventions.

The specific intervention is based on the philosophy of the Tavistock Clinic's 'Under Fives Counselling Service'. Emanuel and Bradley (2008), in their book, have given a concise overview of this type of therapeutic work: the Service offers quick response, brief (up to five sessions) psychoanalytically-based family interventions to parents with babies and young children, with the aim of supporting parents in helping their child back onto their developmental path. Referrals include emotional and behavioural difficulties, such as feeding, toileting, sleep problems, tantrums and aggression. The framework for thinking about the clinical work on offer includes an understanding of psychoanalytic theory and observational skills, allowing the therapist to be in touch with primitive infantile feelings. Of central importance are Bion's concepts of the container/contained (Bion, 1962, 1967a) and of maternal reverie (Bion, 1967b), as well as Bick's notion of second skin containment (Bick, 1968). Furthermore, the clinician takes into account the transference and countertransference experiences that emerge. The sessions are likely to include a gradual exploration of the parental background and its implications for the family, and a simultaneous exploration of the infant or young child's verbal and non-verbal communications through behaviour, play and drawing.

The intervention employed in the Day Care Centre for Children with Autistic Spectrum Disorders shares most of the aforementioned basic tenets of therapeutic work. However, there are some significant differences, since necessary adaptations were made to address the needs of the specific population.

First, the work offered in the Centre is not intended to be a brief intervention, but an open-ended one. We are aware that changes in the duration of a therapeutic intervention influence the dynamics within the therapy room, as all therapeutic elements are closely intertwined (Anagnostaki, Zaharia, & Matsouka, 2017). However, it is a very clear aim of this particular intervention, although a long-term one, to allow for the 'slow unfolding at double speed' (Emanuel, 2008), a paradox that refers to the dramatic way in which children enact their own and their family's predicament in the consulting room, in front of all the family members and the therapists, which speeds up the process of change, and is so characteristic of the brief psychoanalytic intervention offered at the 'Under Fives Counselling Service'.

Second, referrals at the Tavistock Clinic's 'Under Fives Counselling Service' normally encompass milder pathologies. In contrast, at the Day Care Centre we deal with more severe difficulties.

Third, this intervention is part of the comprehensive treatment that the child receives within the Day Care Centre. Special education, speech therapy, occupational therapy, etc. are also on offer.

Fourth, the intervention takes place in a familiar environment. The child is taken out of his/her classroom, in order to meet with the parents and other family members inside his 'school' building. The therapists are also probably familiar with him/her, as

they are bound to have bumped into them at one point or another, walking along the Centre's long corridors. In addition, the therapists have access (both formally and informally) to detailed information about the family and the patient, their history, the child's diagnosis and their 'school' conduct.

Finally, in most cases, as in the case of Jason, we see this kind of intervention as a basic 'prerequisite', an introductory intervention for further long-term work, namely, in most cases, individual psychotherapy for the child and parent/couple support.

In conjunction with the aforementioned tenets, the intervention also follows the basic principles that Houzel (1999) put forward regarding work with parents of children on the autistic spectrum. Establishing a solid therapeutic alliance, deciphering the emotional expression of the child, and working through what Houzel calls the 'paradoxical depression of the parents' – that is, working through feelings of inadequacy and guilt that these parents experience and which are at large projected onto them by family members, by their social environment or even by health care professionals – are all important aspects of this type of intervention.

Background information

Jason was referred to the Day Care Centre when he was three years old. He already had a diagnosis of autism from a public hospital. At the time of the referral, the parents described Jason as not being able to talk or communicate in any way. They added that he did not eat solid foods, refusing to chew. This last symptom worried the parents greatly. The weekly sessions with Jason and his family began approximately half a year after his enrolment at the Day Care Centre.

At the time of our work with Jason's family, the parents were in their early thirties. They had been together since their teenage years. The mother was native to the country; the father had come to the country in his early teens, as an economic migrant. He did not have a steady job, but managed to make ends meet, while the mother stayed at home with the children. Jason was their first child; Daphne, his two years younger sister, came second, closely followed by a third child, a boy, Maximus, who was born during our work with the family. Shortly after Jason's birth, the mother had had a psychotic breakdown. Baby Jason had been separated from his mother during that period, which had also been characterised by intense intra-family conflict. Paternal grandmother took care of young Jason in her own house, mother was taken care of by father in their home, while the parental couple visited the small baby often but with no consistency.

The psychotic breakdown of Jason's mother and the subsequent violent mother-infant separation brings to mind Tustin's writings on trauma (1991), a term she reserved for responses to events which arouse intense feelings of horror, a sense of outrage, and often a feeling of revulsion and turning away. Her contributions highlight the importance of a premature awareness of bodily separateness in the case of autistic children (1981, 1986). She suggests that the emergence of this awareness gives rise to the feeling that part of the body has been lost, especially the mouth, 'gone away' with the 'button' of the breast. Unmitigated terror might ensue, which Tustin sees as a crucial factor in the development of autism.

Clinical material

Detailed accounts of two sessions with Jason's family are presented. The first account is from the second meeting with the family. Next, some information on the therapy's progress is provided. The second detailed account, that follows, is from a session towards the end of our psychotherapeutic work with this family that took place approximately ten months later.

Session I (from the first phase of the intervention)

The recording of this session was an arduous task. Both therapists felt that during the session the room was filled with uncontained, dispersed elements that were difficult to be thought of, put into words or indeed put on a piece of paper.

The father, the mother and Daphne came on time for the session. When entering the building, they bumped into Jason on his way to the canteen and told him to stay with them in the waiting room. We greeted all of them there. On our way to the therapy room, the therapists wondered about Jason's walking difficulty. It seemed as if he was dragging the left side of his body and his left leg. Maybe a neurological problem? Once inside the therapy room, the mother sat on a chair at one corner of the room. The father sat opposite her, at the other corner of the room, and Daphne sat on his lap. Jason sat on one of the remaining big chairs, next to his father's chair. Therapist B commented on that. Jason stood up and went to the toys that were nearby, and started examining them. It was remarkable that none of the children approached their mother during the entire session. It felt as if both of them were trying to keep a safe distance from her ...

Jason, while examining the toys, made a hissing noise. He did not make eye contact with anyone in the room, and gazed at the toys with his eyes almost closed. He stood there, between Therapist B and his father, bringing the toys to his face, one by one, very close to his eyes. While making that hissing noise, his mother asked him twice if he was thirsty and told his father to give him some water. Therapist A was watching the little boy becoming acquainted with the toys, taking in the whole new condition of our presence there. So, she asked the mother why she would think that Jason was thirsty. Then, looking at Jason, she added: 'He seems to have other things on his mind. He is quite busy playing'. The father told the mother: 'Probably you are the one who is thirsty'.

The parents started talking about Jason's food intake. He would not chew. Yesterday, the father had given him a baked potato, Jason had bitten a small piece once, but then had tried to swallow a big piece without chewing it and had almost choked. They went on giving us a lot more details, persistently asking us questions about what to do, what specialist to see, etc ... We commented on the parents' fear about Jason choking: maybe this fear was somehow transmitted to him? The mother then said that once she had refused to give Jason pureed food and had offered him 'regular' food instead. Jason had then said: 'bad'. Mother had felt that he was calling her 'bad', and she couldn't stand that, so she had offered him pureed food again. Therapist A said that it seemed difficult for them to give Jason 'regular' food, 'but dad had tried to do so yesterday. Maybe he wanted to tell us some good news in our meeting today?' 'Clever girl', replied the father.

The mother, then, started talking about her pregnancy to Daphne: how Jason would pull her blouse up when she was pregnant with Daphne, how this pregnancy was detrimental to Jason, because this is when his illness started ... She continued talking about her pregnancy with Daphne and how harmful it had been to Jason, but it was difficult for us to follow her thoughts; her words seemed to lack cohesion. She kept on asking us: 'Do you understand?'. She then took a piece of paper and used it as a fan. She said: 'I am going to burst'. At this

point, she announced that she was currently pregnant again; Jason had been the first to understand this, long before she had found out herself, because he had come and pulled up her blouse. Then she started talking about her bad relationship with her own mother: 'My mother knows what to say in order to hurt me. [...] She tells me that I am to blame for Jason's illness. She made me lose two babies and now she made me lose one of the twins that I am carrying.' Both therapists felt very worried about the mother. We told her that all these thoughts are difficult to bear, especially in her present condition, and offered her the possibility of an individual appointment with one of the Day Care Centre psychiatrists, which she accepted. The father then said, in a rather demeaning way, that his mother in law was worse than his wife. He said that she was scared of everything ('of her own shadow', as the Greek saying goes). The mother disagreed, saying that her mother was not scared of anything.

Meanwhile, Daphne had stepped away from her father's chair and had silently come next to Therapist A, standing in front of the small table that had sheets of paper, crayons and felt-tip pens on it. Therapist A asked her if she wanted to have a look. Out of the blue, father threw a ball to Daphne's head in a seemingly playful way. Daphne did not react; she stared at Therapist A, with a frozen, frightened gaze. Jason approached the table and looked at the felt-tips. Therapist A asked him whether he wanted to paint. The father stood up and took a piece of paper. He started drawing some shapes, telling Jason to do as he does. Therapist A then said that maybe Jason was interested in the colours. Mother said that he knew the names of colours. Therapist A said that Jason was perhaps showing us in his own way what he likes and what he can do. The father turned to the mother and said: 'That goes to you. You should observe him closely.' Mother reacted to that and said: 'Yeah, like you are the smart one and I am the dumb one'. The session time was up. We renewed our appointment. The parents and Daphne left, while Jason returned to his classroom.

This was an almost unbearable session for the therapists. We both left the room feeling literally sick, wondering how we could contain, for the whole family's sake, all the crude projections and destruction that seemed to have filled up the room.

Although one could elaborate on the neurological deficiencies in the clinical picture of the little boy, our understanding of Jason's refusal of solid food was that he did not simply refuse to process the food his parents provided him. He might have simultaneously been closing his mind to his own emotional experience and that of others. In Tustin's work, linking experiences are provided by satisfying nipple-mouth sensations and by being encircled in the mother's arms, in the ambience of caring attention. Tustin (1972) categorically states that if this sense of primal linking is lacking, processes exclusively centred on the child's own body compensate for the lack. Following Winnicott's suggestion that oral function is organisational to the psyche (1936), we propose that Jason resorted to food refusal (and perhaps refusal of all communication) as a means of protecting himself and a way to deal with the projections of his psychotic mother. We believe that he employed what Gianna Williams (1997) calls 'no entry defences', which include the intention to reject food intake, as a displaced repudiation of the unbearable feelings projected into the patient, signifying a specific failure in the container/contained relationship.

It was clear to us that young Jason lacked an effective internal structure, which normally develops from the experience of 'being held' by a 'good enough mother' (Winnicott, 1960). In fact, we thought of Jason as being flooded by 'omega function' (Williams, 1997), a function that derives from the introjection of an object which is both impervious to and overflowing with projections. Just as the introjection of alpha

function is helpful in establishing links and organising a structure (Bion, 1967a), the introjection of 'omega function' has the opposite effect, disrupting and fragmenting the development of personality.

Elaborating on our countertransference feelings, we too, the therapists, felt overwhelmed by what seemed like delusional material. Our confusion grew stronger as we didn't know what was true and what was not. We felt a level of dysphoria in a bodily way, as there were too many unthinkable fragments of thoughts to be contained. What was apparent was the fact that the current pregnancy was stirring persecutory feelings, along with a paranoid aspect of the relation of the mother with her own mother.

Another important aspect in the clinical material involved father's wish to position himself with the (imagined) omnipotent side of the therapists, as well as his effort to undermine the mother. Our acceptance that we do not know everything and our suggestion of appropriate help for the mother (i.e., psychiatric help), suggested very early in our collaboration with the family that we were there for them, as a system and individually, and that together we could think about their needs, thoughts and feelings; but that we had no magic solutions or answers to everything.

Some notes on the therapy's progress

The first five sessions with the family were dominated, it felt, by the presence of bad, persecutory objects. The sessions were difficult to bear, an experience that interfered with our capacity to think. Gradually, however, by recognising and staying close to our countertransference feelings, we managed to put up with the family's violent projections, containing our own feelings of inadequacy, destruction and abandonment, and facilitating the unfolding and exploration of the clinical material. Making use of our abilities of observation, free floating attention and empathic listening to the psychic material that came up in the session, we gradually became more able to form some thoughts concerning the psychic function of the members of the family, both separately and as a therapeutic couple, and we got involved in an integrating discourse with the parents and the children.

Apart from the material introduced by the parents, Jason, who came to the sessions straight from his classroom, sometimes holding a toy, sometimes mumbling a song, clearly introduced his own material. The therapists recognised that and made use of what he brought to the sessions as new channels of communication between him and the parents. The special communication the boy had established with one of the two therapists (narrating to her a fairy-tale in his own fragmented way, or inviting her to play and sing with him) provided the parents with an opportunity to observe their son and to think about him as an individual person, leaving aside, if only for a little while, the projections of their own raw and unprocessed feelings. Observing the child (by making use of the therapists' benign way of observing) paved the way for the parents to observe themselves as well, their own emotions and reactions, and to attempt some meaningful connections. Thus, the need to constantly go back to Jason's symptoms in a sterile way gradually diminished.

Feelings of competition often emerged within the parental couple. In addition, sometimes competitive feelings emerged within the therapeutic couple as well: who

was getting more attention from the children, who stood for the parental figure in the transference, what impact did one therapist's comments or the other's silent observing stance have? The detailed recording and discussion of the material after each session were of fundamental importance, offering the therapists their own vital space to think about the raw material this family provided. Most importantly, the recognition of these emotions and their containment neutralised their toxicity and facilitated the creation of a coherent narrative, regarding the family's current situation and the difficult life stories of the parents. The early life stories of both mother and father had been dominated by deprivation (physical and emotional), lack of parental care and extreme experiences: it seemed that at times, in both their lives, there had existed either a 'perfect' symbiotic partnership, or relationships characterised by envious and destructive elements.

The presence of the children in the room, particularly the observation of their reactions when painful emotions and traumatic past events were referred to, served an important facilitating function: it contributed to greater resilience with regard to the violence of early traumas, as it facilitated the differentiation of an-other-than-this 'here and now'. Eventually, the movements and play of the children in the room set the adults in motion as well. The children were gradually involved in more developmentally appropriate games, and slowly they came closer, both physically and emotionally, to their mother, who would respond in a positive way. Halfway in our psychotherapeutic work, the mother was able to invite the children to play and enjoy a game with her. She could now provide a psychic space for them, without the impelling need to get rid of (i.e., project) her destructive feelings of inadequacy and confusion. Father, on the other hand, was enabled to abandon his omnipotent position, and his derogatory stance towards mother became milder. Slowly, he started to take in some of the therapists' careful comments on his sometimes intrusive and penetrating way of 'being with another' (one remembers his sudden throwing of the ball onto Daphne's head, or his hastiness in showing Jason how to draw). Although evident from the very beginning of our work together, we feel that a moving aspect of our collaboration with the parents, which became more and more obvious as the intervention progressed, has to be particularly acknowledged: the parents' mutual commitment to receiving help for their child and their family.

Session II (from the final phase of the intervention)

The next session that will be described took place at the beginning of the following academic year. The Day Care Centre had closed for the summer break, and by mid-September nobody knew whether or when it would re-open because of underfunding (during the period of the Greek financial crisis, many Day Care Centres closed down). The director of the Day Care Centre had held a strenuous meeting with the families of all patients, informing them about the current developments, and letting them know which therapeutic interventions would continue (until further notice). We had decided – having discussed our options in a clinical meeting with colleagues – to continue the weekly sessions with the family for at least the next three months. Therefore, Session II took place amid the uncertainty and anxiety concerning the Day Care Centre's future, fifteen days after the long summer break, and ten days after the birth of the family's third child.

We were touched and somewhat surprised to see all of them coming together (mother, father, Jason, Daphne, and newborn Maximus). We saw Jason smiling and walking more steadily; he did not remind us of the staggering child he used to be. He half closed his eyes while looking around. Was he setting a sensory limit to the images he perceived, we wondered? Therapist A asked him if he wanted to see the Day Care Centre again, as he had not seen it for a long time. Jason grabbed the therapist's hand straight away and led her to the classrooms. He got into his classroom, looked at the desks, and searched for the toys. The therapist told him that he must have missed everything in here, and he uttered the names of some of his classmates and that of his teacher.

Therapist A: 'You kept them in mind. Maybe you expected to see them today, but the classes in the Day Care Centre have not started yet. You and your family have come, though, to meet with L. A. (Therapist B) and myself.'

Jason willingly left the classroom and came to meet the rest of the group. Inside the therapy room, the parents had sat in their usual places. Daphne was on her father's lap, looking sad and cautious. Maximus was in the booster seat, next to his mother's chair. We could only see half his face, as he was covered up to the nose. The mother looked good. However, both parents seemed worried. They asked us about the Day Care Centre, what was going to happen with this place.

Therapist A: 'Jason was also concerned and wanted to see his classroom.'

'Really?', asked the father, with concern.

Therapist B: 'We haven't met for a long time.'

The parents nodded in agreement, and went on asking about the Day Care Centre, the staff here ... 'How are you? Do they pay you?' asked the father. 'Things aren't easy ... ' said the mother. Meanwhile, Jason had found a toy-phone which he used to play with in previous sessions and Therapist B commented on that, saying that he might prefer to play with some of his old toys, rather than listen to this difficult conversation.

The mother said that Jason was obsessed with computer games. 'How are you?' we asked her. She replied that she was still struggling with pain, following the baby's birth. The baby had been kept away from her for seven days, due to jaundice. 'I felt really bad when they took him from me. You should have seen me back then. Only my husband could see him, and only for a few hours. When I got back home, Daphne did not want to look at me at all. Jason was calmer; I let him do his own thing to stay calm. The thing is that Daphne has to learn to do her own thing too. Not to imitate Jason.'

In the meantime, Daphne had started moving from the father to the mother and back again. Parents commenced talking about their well-planned efforts to find an afternoon activities programme for Jason. They thought this was essential. The mother said: 'Before the baby was born, when dad left for work, things weren't easy for me. I was pregnant, with two little children and I couldn't cope. We really need help.' Daphne was on her mother's lap now. Mother said to her: 'Here's the baby, look at him!' She then told us that Daphne looked after the baby a lot, that she was really good with him. Jason looked at his mother and sister.

Therapist B: 'We are talking about your brother and sister, Jason.'

He turned his gaze back on his toy. 'That's what he does!' said the father. 'He isolates himself, doing his own thing.'

Daphne looked at Therapist A and smiled. 'You feel more comfortable now, don't you?' asked the therapist. 'She doesn't say a word', said the mother, and Daphne looked at her and back at the therapist. 'Yet, she listens and understands really well what we are talking about, and waits to see what we will say next. She is listening to you talking about her. She doesn't seem to imitate Jason now', the therapist commented. 'You're right', replied the mother. She stood up, got three soft toy cubes, sat down next to Daphne and showed them to her.

The father took the toy phone from Jason's hands and hid it. The mother then gave two or three cubes to Jason, too. Jason wandered around the room, looking for the toy phone. He could not find it, so took one cube and went to his mother. As he walked by his sister, who was playing quietly with her cubes, he pushed her down. Daphne looked up, at her parents and Therapist A, expressing her anger. The parents asked Jason why he had done that. Therapist A said to Daphne: 'You got scared, you didn't expect that and it seems as if you were waiting for mum, dad or even me to say something ... but you didn't say anything to your brother for pushing you down, either ...' Then Therapist A turned to Jason and said: 'Jason, you were upset. Father took the phone, Daphne was with your mum, you were cross and you hit her.'

Mother smiled and said: 'Look how they both look at Mrs. T. (Therapist A).'

Therapist B: 'Because she talks about what happened, and they both understand really well.'

Father: 'We have to do something with Daphne. She needs something to do during the day. I also have to find a new job. We can't wait anymore.'

Then the parents described how they had asked for the maternal grandfather's help, but he had once more refused. The mother talked about her relationship with her absent father; he had never been there for her. At one point, she said: 'Even now that I'm talking to you about him, it feels like I'm choking.' She talked in a sad, yet mild manner about how tired she really was, about her problems, about feeling abandoned by the people close to her. We felt deeply moved by her narrative.

While the mother was talking, the two children were playing quietly; Daphne with the cubes her mother had given to her, and Jason with a toy clock. When the mother finished, Therapist B said that there were a lot of things to talk about 'and we can talk about them here without choking'.

The session's time was up. We discussed the schedule for our next appointments. Both parents said that they wanted to come every week, but the mother asked whether it was possible to move our sessions a little earlier, so that she could take Jason to a swimming class afterwards and have some time alone with her daughter. As we were getting out of the room, Jason grabbed Therapist A's hand and led her to the door. 'Would you like to see your class once more?' He nodded. The father turned to Daphne: 'Go with your brother.' Jason got angry and hit his father's hand. Daphne stayed still, while Jason had already gone out of the room. 'Please say something to him' the mother told us. 'We don't have to be together all the time ... stuck to each other ...' "

Discussion

As stated in the introduction, our primary objective with this family was to establish a cohesive narrative of the family's story as a whole and of each member separately. This effort implied, first of all, that their story would become an object of thought, and that internal and external difficulties would be recognised without disrupting the story's cohesion. We argue that the intervention described here provided this family with the necessary psychic space to process their fragmented history. This was not an easy task, since the whole family's story had involved a journey full of deprivation, traumas and frustration. However, based on the clinical material, we maintain that the therapists' attempts to become the 'thoughtful' witnesses of this journey and to transmit, at least partly, this capacity to the members of the family, were fruitful.

The clinical material presented here illustrates the emotional and psychic transformation of the family during the course of the intervention. In the first session

described, primitive emotions and fragments of thoughts were thrown ‘en masse’ into the room, seemingly taking up the entire space, without being an object of thought. For instance, the (pregnant again) mother exclaimed that she would ‘burst’ when talking about how her previous pregnancy had been ‘detrimental’ to Jason, but she did not seem to make the connection between this bodily sensation, the anxiety feelings regarding her pregnancy, and the painful things she was recounting at that moment. She reacted as if this sensation was purely somatic, and dealt with it by taking a piece of paper and using it as a fan.

The projections communicated were primitive, the children being the main recipients. A palpable example of a projection, that the father managed to see through, occurred when the mother told the father to give water to Jason, although he had shown no signs of being thirsty. To our understanding, the avoidance, on the part of the children, of any bodily proximity to the mother indicated that they felt threatened by this mother who massively projected onto them and, at certain points, was not able to provide any containing function. It is noteworthy that at the end of that session, we, as therapists, felt that our own ability to think and make connections was also attacked. This family’s adhesive way of relating made us feel it was imperative to differentiate the needs and emotions of each family member. Finding a ‘good enough’ base in our therapeutic alliance made it possible for us to endure our inadequacy and feelings of ‘not knowing’. We, as a therapeutic couple, functioned alongside each other and with each other, allowing, thus, the differentiation of needs and facilitating multiple identifications.

In the first sessions with Jason’s family, he had failed to establish reciprocal eye contact. That is a well-known clinical feature of autistic children. The divergence of the gaze impedes the co-construction of shared emotional meaning between child and caregiver or, as Trevarthen (1979) puts it, the development of primary intersubjectivity. By closing his eyes and mouth (refusing to eat/chew), Jason avoided any intersubjective communication; this was perhaps his way of keeping strong projections at bay. Additionally, the way he carried his body, and especially the way he walked, attested to the serious disruption of the first stages of body/psychic development. We wondered whether this could be a result of what Tustin describes as ‘primary depression’, with the accompanying bodily sensations of falling infinitely and of annihilation through liquidification (1991).

As the therapeutic work with the family progressed, the therapists focused on making sense of the states of mind of the family members. By using simple words that could easily be understood, the therapists encouraged all members of the family to take part in the chain of human communication, which is primarily based on shared experiences stemming from psychic situations. Understanding and expressing emotional states were facilitated. The parents themselves progressively became more actively involved in taking care of their children and their own needs.

The use of Esther Bick’s method of psychoanalytic observation enabled the therapists, and eventually the parents, to observe and think about the ways the little boy used his body and expressed himself. We argue that our focused attention on him provided a basis for the establishment of reparation. According to Berke and Schneider (2003), the concept of reparation of the damaged early internal object encompasses not only the need to repair, but also to re-‘pair’, that is to re-establish torn and broken relationships (Haag et al., 2005; Weinberg, 2016). Admittedly, in our work with Jason,

we used a wider definition of primitive reparative acts and precursors for reparation, as can be the case in therapeutic work with very primitive emotional states (Weinberg, 2016). Contemporary literature recognises an essential primary aspect of reparation, independent of the ability to perceive the object as separate. For instance, it has been argued that the therapeutic setting with its special characteristics provides a reparative environment which can be taken in even by severely regressed patients (Alvarez, 1992; Berke & Schneider, 2003; Durban, 2014; Weinberg, 2016).

Of course, the role of the object in creating the conditions for making even the most primitive form of reparation possible is a determining factor. The therapists' stance, recognising and sometimes encouraging the development of a relationship with the object, pointed in this direction, and definite progress could be observed during the course of the intervention. Jason gradually became more stable, capable of standing on his own feet, moving towards his parents, the therapists, his sister. One could also observe the development of instances of 'joint attention' (Bruner, 1983), allowing Jason to share with other people the experience of a third object or event. In other words, he was becoming able to participate in triadic exchanges that were related to some primitive form of helpful projective identification (Haag et al., 2005). In the context of those exchanges, one could recognise moments during which young Jason felt 'solid' and would open up to the outside world, looking for something external to 'hold on' to (the toys, his mother, the therapist's hand that he grabbed when walking to his class).

During the early phase of our work with the family, we often experienced feelings of despair in our countertransference, which possibly reflected the family's fragmented psychic function and the primitive phantasies regarding a traumatic breakdown. Still, there were also moments of hope, gradually more and more so, which probably mirrored the family's hidden search for reparation. It has been argued that precisely this ability to move freely between states of despair and hope is a crucial factor in maintaining mental space, in reaching for a better understanding of the autistic child and promoting development (Durban, 2014). Indeed, based on this feeling of hope, we decided to continue the sessions with Jason's family, despite the grave financial condition of the Day Care Centre.

In the second session described, that took place approximately ten months after the first, amidst the Centre's financial crisis, with, however, the therapeutic intervention well under way and the therapeutic relationship firmly established, we observed clear differences in the family's function. The children approached the mother, and she in turn played with them. She was in a position to connect her emotions to what she said and did in the therapy room ('... now that I'm talking to you about him, it feels like I'm choking'). Both parents were able to observe their children and make connections as to what might actually be of interest to them, and as to what their needs might be. The 'here and now' of the intervention was gradually accepted by the family as an internal regulator for their emotions: a space where primal fears could be contained and where internal experiences could be communicated (Tustin, 1991). At the same time, the parents were exhibiting a capacity for concern (Winnicott, 1963), not only for their children, but for the therapists as well, and all those who worked at the Day Care Centre.

In addition, as the family's narrative became more coherent, the family members became more differentiated. The different needs of each family member were recognised (the dad must get a steady job, the mother needs time to herself, the son needs a new

therapeutic setting, the daughter needs to have her own point of reference so as not to imitate her brother ...) The mother's words at the end of the session (*'we do not have to be [...] stuck to each other'*) confirm this movement towards differentiation.

On the whole, it seems that the therapists' containing function was, at least partially, internalised by the parents, who gradually felt less threatened by their children's demands and behaviours, and could increasingly function as containers for their own and their children's sake. This is consistent with the findings of recent research with families attending a psychoanalytically oriented early intervention programme, indicating that the implementation of such interventions can alleviate parental stress, and thus can support the parental capacity to efficiently deal with the high demands of early development (Anagnostaki, Kolia, & Layiou-Lignos, 2019).

Sadly, the work with Jason's family was terminated prematurely, due to the Centre's financial circumstances. However, the parents made use of the therapists' suggestions and managed to find a clinical setting that could offer psychotherapeutic support to Jason, Daphne and the parental couple. Thus, in some way, we felt that they would pick up their long journey from where we left it. We firmly believe that the psychoanalytic intervention presented here, that is, the starting point of their journey, provided the family as a group and each member individually with valuable resources that will hopefully accompany them in the future. We also believe that this type of psychoanalytic intervention can be used in general as a starting point in the therapeutic work with families with children on the autistic spectrum, with beneficial outcomes for the whole family and the child.

A different epilogue

When this paper was prepared and submitted to the JCP, the Journal asked us to provide the family's informed consent regarding the publication of the paper; according to the Journal's newer guidelines, general consent given to the Day Care Centre is not adequate. Acquiring consent from the family proved to be quite complicated (it appears that nothing in our work with this family was ever easy!) The Day Care Centre, where the therapy sessions were held and all the patients' files are kept, has been closed for more than three years. When we managed to contact the Day Care Centre's Board, we were confronted by their refusal to give us the contact details of the family, for the exact same reasons that the Journal required consent for, namely for the protection of the family's personal data. We felt puzzled and frustrated, faced with this contradiction, stemming from the obligation of both institutions (Journal and Day Care Centre) to protect the patients' privacy. We thought we were at an impasse, unable to publish the results of our work and to present this intervention to a large audience; we felt that this intervention had seemed to help this family and we believed these ideas could benefit other colleagues and their patients. However, we managed to hold onto hope and persevered.

Finally, the long discussions with the members of the Day Care Centre's Board, reassuring them that the anonymity of the family is guaranteed and that the publication will benefit all former patients and employees, being almost a reparatory act, were successful, and we were given the information we needed in order to find Jason's family.

Communicating with the family was deeply moving and rewarding in a way. The parents were very happy to hear from us and expressed their gratitude in many ways:

they told us that they still think about our work together, that they felt we had ‘supported them’ (we believe that this is one way to express the feeling of containment), and that they had talked about us to all the people who had since become involved in Jason’s treatment. Of course, they provided their consent for the publication of the paper.

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No potential conflict of interest was reported by the authors.

Notes on contributors

Maria Tselika, M.Sc., Clinical Psychologist, Child and Adolescent Psychoanalytic Psychotherapist. She is a member of the Hellenic Association of Child and Adolescent Psychoanalytic Psychotherapy. She has worked for several years at the psychoanalytically oriented ‘Early Intervention Programme’ addressed to families with infants/young children in the Department of Child Psychiatry, National and Kapodistrian University of Athens Medical School, ‘Aghia Sophia’ Children’s Hospital, and has contributed to the introduction of this type of psychotherapeutic work with children on the autistic spectrum. She currently works privately.

Lida Anagnostaki, M.Sc., PhD., Psychologist, Child and Adolescent Psychoanalytic Psychotherapist, Associate Professor of Psychoanalytic Developmental Psychology in the Department of Early Childhood Education at the National and Kapodistrian University of Athens. She is a member of the Hellenic Association of Child and Adolescent Psychoanalytic Psychotherapy. She has worked for several years at the psychoanalytically oriented ‘Early Intervention Programme’ addressed to families with infants/young children in the Department of Child Psychiatry, National and Kapodistrian University of Athens Medical School, ‘Aghia Sophia’ Children’s Hospital, and has contributed to the introduction of this type of psychotherapeutic work with children on the autistic spectrum.

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