Smoke and Mirrors
How to Saw a Soul in Two
Dedication

To my tutor Anne Worthington who encouraged me to conduct field research.
Acknowledgements

With grateful thanks to Louise Cooke for transcribing the audio recordings of the research interviews and Debbi Scholes for proofreading the manuscript.
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### Appendix N  Autism: a Description

### Appendix O  The National Autistic Society’s Views of Psychoanalysis

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Dissertation – SPL (PSA) 4725: Smoke and Mirrors.
Part One – Smoke Gets In Your Eyes

‘For now we see through a glass, darkly...’ 1 Corinthians 13 v 12

What Autistic People Need in Psychotherapy

Autistic people’s mental health needs are not being met. A recent interview on Radio 4’s Woman’s Hour (broadcast 11.06.10. see transcript: Appendix A) discussed this in the context of young people. The interview discussed the fact that autistic people often have undiagnosed mental health issues alongside their autism, such as depression, Obsessive Compulsive Disorder and anxiety, and that these issues are preventable with support, but support suitable for autistic people is usually not available.

The term autism is used by different professions – psychiatry, psychology, psychotherapy – without agreement on the cause or nature of autism, appropriate treatments or possible treatment outcomes (see Appendix K). Autistic people, by definition, have difficulty communicating, while they and their carers (often family members as was the case for Holly in the interview) usually have a layperson’s knowledge of medicine; so autistic clients may not know what to expect from psychotherapy. (The Woman’s Hour interview discussed psychotherapy in general; I will discuss psychoanalysis in particular later in this paper).

Add to this the fact that the relationship between a psychotherapist and client is a relationship like no other, and that the autistic client, already socially lost, may well not know how to ask for what they need in therapy. (The autistic person cannot apply rules they have learnt about socially appropriate behaviour to the therapy setting, such as knowing it is polite to take it in turns to talk, or knowing subjects it is not polite to raise with new acquaintances).
The Woman’s Hour interview featured the case of Holly, an autistic young woman with co-morbid anxiety. Psychiatrists treating her anxiety over-ruled her autism diagnosis. Dr Gould pointed out in the interview that misdiagnosis of autism itself as mental health issues, such as eating disorders or attachment disorders, is common and problematic as it means the treatment will not be appropriate; the wrong issue is being addressed, using methods the autistic person cannot relate to. Holly was asked to put her emotions into words and analyse her feelings, which caused her to become confused. This is not surprising given the research conducted by Uta Frith into how autistic people process information (Frith, 1989). The approaches recommended in the interview by Barbara McIntosh of the Foundation for People with Learning Disabilities were adapted Connotative Behavioural Therapy, therapy via email to avoid face-to-face contact and using visual images, not just speech.

The National Autistic Society recognises that autistic people are particularly vulnerable to depression and anxiety (Deudney, 2004, pp 3-4). The society also recognises that autistic people will need to talk about their feelings, even though they may find this hard. ‘Some research has shown that a counsellor or psychologist using Personal Construct Theory may be able to help. Alternatively, people may find that they would prefer to see someone who is a Person Centred counsellor. These types of counsellors talk about feelings more than Cognitive Behavioural Counsellors.’ (See the copy of the National Autistic Society (NAS) factsheet: Appendix O). But psychoanalysis is not suggested.

Likewise, Tony Attwood, a clinical psychologist who specialises in autism, is sceptical of the value of psychoanalysis for autistic people. ‘In my opinion, traditional psychoanalytical psychotherapy has very little to offer a child or adult with Asperger’s syndrome; an opinion shared by some psychotherapists (Jacobsen 2003, 2004)’ (Attwood, 2007, pp 316). (Jacobsen is referred to by Joan whom I interviewed while researching this paper: see Appendix E).
There are three issues autistic people bring to therapy. The issues of life we all have, the issues of living with autism and the issues surrounding any co-morbid mental health condition. Because autism is a communication disability, the autistic client will bring to therapy an atypical experience of life in relation to all three areas. The client may not have a full understanding of what other people think and feel or an understanding of their own feelings. In dealing with all this, the autistic client needs to be communicated with in a manner with which they can relate.

The mental health sector needs to respond with research, training for psychotherapists and their supervisors, sharing best practice, developing services and signposting autistic clients to appropriate services. Is there a role for psychoanalysis?

My Hypothesis

My hypothesis was that books like Mark Haddon’s *The Curious Incident of the Dog in the Night-Time* (Haddon, 2004) and films such as Karan Johar’s *My Name Is Kahn* (Johar, 2010) mean that people are aware of autism; asking themselves if autism explains their difficulties and arriving in therapy with this question in mind. Meanwhile, media coverage of biological causes for autism (Baron-Cohen et al 2000, Cole, 2010, Wakefield 2004) will have raised awareness amongst psychoanalysts of the need to reconsider the classic psychoanalytic view of autism. This view is that autism is caused by a difficulty in the infancy of the affected person in the bonding between infant and carer (Feinstein, 2010, pp 43).

I wanted to find out the extent to which psychoanalysts are changing their approach when working with autistic adults (those who use speech to communicate), in response to scientific discoveries and also to the client’s needs.

My research sample was too small to draw conclusions about the response the psychoanalytic profession is making to autism. However, as the only writing I found
which even mentions autistic adults in psychoanalysis is two chapters in *The Many Faces of Asperger Syndrome* edited by Rhodes and Klauber, 2004, I believe my findings will be of interest to colleagues.

**Methodology**
I used qualitative interviewing with psychoanalysts to find examples of approaches being used. I asked about the different stages an autistic client would go through in entering psychoanalysis and having treatment. I tried to phrase questions without suggesting a correct response. This resulted in unclear questions, but valuable responses.

**The Sample**
I interviewed six psychoanalysts. I sought a range of experience with autism, because autistic clients could find their way into the offices of any number of psychoanalysts.

All the interviewees worked in private practice, so did not represent the views of an organisation such as the NHS. One interviewee, Stephen, also worked for a multi-disciplinary team in the NHS and, while he included insights from this work in his answers, he does not speak for the NHS.

To place my findings in the context of autism mental health services in general, I also interviewed two National Autistic Society-listed psychotherapists – Joan and Lucy – and Brian, a psychiatrist working in the field of autism.

The NAS does not have a policy on what view of autism or techniques a therapist should use (see correspondence with NAS: Appendix O). Both NAS-listed interviewees have a psychoanalytic/dynamic base, several years’ experience of working with autistic clients and have developed their own methods.
Brian’s psychiatric work is part of a specialist NHS multi-disciplinary autism service, but again he spoke from a personal perspective. His interview highlighted the importance of co-ordinating the work of different mental health professionals.

The Nameless Nine
My research interviews were carried out in the UK in the summer of 2010. The interviewees’ pseudonyms are; Brian, Colin, Douglas, Joan, Lucy, Marsha, Peter, Stephen and Titania.

Summary of Findings
The innovation which I discovered really encouraged me. I had feared that psychoanalysis would increasingly be seen by the autistic mainstream as a dangerous anachronism. I also encountered some pitfalls, which I discuss here so that lead balloons are not re-invented.

The Questions

The Practitioners’ Backgrounds

Orientation
Firstly I asked about orientation. I wondered how much orientation influenced responses to autism. Often orientation was evident in the interviewee’s approach. However, on the whole, orientation did not determine the techniques adopted.

Brian, our psychiatrist, has an object relations focus (a Kleinian leaning with a hint of Jung – descriptions of their work in Appendix M). This focus believes an infant forms a sense of self in the world through internalizing aspects of their carers. Such a process would be atypical in families with autism.
Colin is influenced by Lacan, Laing and phenomenologist philosophers. (Descriptions of their work in Appendix M). Laingians work through a strong relationship with the client; Lacanians see the client’s choice of words as a clue to their understanding of the world; and the phenomenologists consider the nature of consciousness, which for psychoanalysis raises issues on working with the unconscious. Autistic people have trouble with relationships and communication, so this orientation needs to be used carefully with autistic people.

Douglas started life as a humanistic counsellor and came to psychoanalysis via Jung. This took the form of a journey from forming a bond with the client and reflecting the clients’ experience back to them, to seeing unconscious motifs common to all people (See description on Jung in Appendix M). (Whether this symbolism is something autistic people have in common with others is debatable, as autistic people tend to be literal thinkers (Deudney, 2003, pp 3-4)).

Joan, an NAS therapist, started as a psychodynamic therapist and now uses elements of other approaches, such as Client Centred (humanistic) and Cognitive Behavioural Therapy in response to her autistic clients, so has travelled the opposite way to Douglas.

Lucy, an NAS therapist, has an object relations focus and now uses adapted listening skills and some Cognitive Behavioural Therapy with her autistic clients.

Marsha is a retired attachment psychoanalyst. As the psychoanalytic profession sees issues in attachment as the cause of autism (Feinstein, 20120, pp 57), this was an orientation I wished to include in the study.

Peter is a Kleinian (description of Klein’s work in Appendix M) with some Laingian influence and fits into the object relations orientation.
Stephen is influenced by Lacan, Laing and the phenomenologist philosophers. Stephen’s orientation was similar to Colin’s, but was applied differently in the light of his experience of autism.

Titania is Lacanian without the addition of philosophy, so provides a contrasting approach to that of Colin and Stephen.

So, overall, I interviewed a psychiatrist, a psychoanalyst and a therapist on the NAS list, who all had an object relations focus. I also interviewed one psychoanalyst with an attachment base – an orientation that grew out of the object relations schools as Winnicott and Bowlby (see Appendix M), built on the work of Klein.

The other main cluster of orientation was Lacan, Laing and phenomenologist philosophers, with two adherents among the psychoanalysts interviewed and one straightforward Lacanian psychoanalyst. Lacanians think infants develop a sense of self through a mirror phase, rather than object relations (Leader and Groves, 1995). Lacanians and object relations theory see autism as psychosis (see Stephen’s and Titania’s interviews; Leader and Groves, 1995; Tustin, 1986).

The other main psychoanalytic school represented was Jungian and one psychoanalyst interviewed aligned himself to Jung to an extent. This orientation looks at the relevance of culture, the arts and spirituality (See Appendix M). All topics on which an autistic person is likely to have an atypical view (see Joan’s interview).

Both NAS therapists also used non-psychoanalytic therapeutic techniques, which offered the study a contrasting response to autism.
Training
I anticipated that many training programmes for psychoanalysts would barely mention autism, look only at children or only at ‘autistic’ states of mind, which anyone can have (Tustin, 1986). This proved to be the case, and orientation had no bearing on whether someone received training on autism.

None of the interviewees had had training on working with autistic adults. As Joan said, such training does not exist for any type of psychotherapist. I discovered that the interviewees had put together the little they had learnt in training with what they had come across in the media or learnt themselves from books or experience, and drawn their own conclusions as best they could.

Peter, a Kleinian, had heard autism mentioned within the context of object relations. (Probably as an example of what happens when such relations go wrong, although this view of autism is disputed, see Feinstein, 2010). Lucy, an object relations therapist, was familiar with child development theories from her studies, such as the work of Frances Tustin on withdrawn children. Brian, a Kleinian, is trained to carry out psychiatric assessments to diagnose autism, particularly in children. Information on working as a psychotherapist with autistic children was available in his training when he asked for it. Marsha, our attachment therapist, had no training on autism.

Colin and Stephen had not had training, but Titania’s Lacanian training had included a guest speaker on infant autism, who looked at bonding issues.

Douglas, our Jungian, was also familiar with Frances Tustin and the autistic barriers she claims all people can have in adulthood (Tustin, 1986); writing he came across when training.
Several interviewees had done their own reading or learnt on the job. Peter worked for a couple of months on a project offering play therapy to infants, and Brian works with autistic adults in his job.

Joan had no training on autism when studying to become a psychodynamic therapist and has since been to every seminar she could find. What she found – work experience, workshops – was focused on children. Several interviewees had to adapt what they had learnt about children or typical adults for autistic adults.

The training offered generated these views: Brian referred to his psychiatric training and using drugs to treat mood rather than therapy (to deal with object relations), while Peter thought in terms of object relations with autism caused by problems for the autistic infant’s carer in holding the infant's needs in mind.

Marsha’s attachment training suggested that autism just happens, which is surprising given that attachment issues have been the traditional psychoanalytic explanation for autism (Feinstein, 2010, pp 56). Lucy had a more developed explanation of attachment and autism, which she had adapted with other information about autism. She described the complexity of having a genetic potential and an environment in which this developed.

Colin gave a detailed ‘textbook psychoanalytic’ (see Feinstein, 2010, pp 56) description of autism being a psychological withdrawal in response to intrusive care in infancy by ambivalent carers. While Stephen, who has a similar orientation, drew on the philosophical parts of his background and saw autism as a metaphor for how someone relates to the world. Stephen had moved from looking at causes to description; making the concept of autism metaphorical. As autistic people struggle with metaphor (Deudney, 2003, pp 4), this is ironic. Titania, a straight Lacanian, saw autism as a psychotic structure, which she said for Lacanians does not necessarily mean someone is mentally ill. Colin also mentioned these structures.
Douglas, our Jungian, thought in terms of Tustin’s barriers in the mind, which any adult can have and are a neurotic structure (Tustin, 1981), in contrast to the psychotic structure Colin and Titania mentioned.

Joan’s psychodynamic training had not mentioned autism and her own research showed that autism is a genetic condition.

So, overall, the little training offered resulted in a mixture of views about the causes and nature of autism.

Causes of Autism
There are two views on the cause of autism. The classic psychoanalytic view believes that all people can be in autistic states of mind (Tustin, 1986, pp 101), and that such states are caused by a difficulty in infancy in bonding between infant and carer (Feinstein, 2010, pp 56). Other researchers see autistic conditions as differences in cognitive processing, with biological causes such as genes (Frith, 1989, pp 77), hormone exposure in the womb (Baron-Cohen, 2000) or vaccination (Wakefield, 2004). The difference is whether autism is psychological or neurological.

I anticipated that those with a neurological view would have different approaches to working with autistic clients from those with the psychological view. However, many interviewees had no clear view on the cause of autism and innovation from different interviewees was similar. Often, no connection was made between views on the nature of autism and working methods.

Inherited
I asked the interviewees if autism was inherited. I had in mind genetics, but to avoid prejudicing responses, did not say so. I should not have used the term inherited, as inheritance is not just from genes but could be copying a carer’s behaviour – as Colin pointed out. Lucy and Brian added that if autism is genetic, then autistic
people have atypical social role models in their families, so it is hard to tell what behaviour is genetic and what is the result of environment.

There was a surprising amount of assent that autism was genetic, given that infant bonding being causal was also widely expressed. Several interviewees were attempting have a foot in each camp.

Joan was clear that autism is genetic. Lucy thought there could be a genetic predisposition and that patterns exist in families. She drew a distinction between inherited and induced autism, noting that deprived children who display autistic traits can, to an extent, recover, but that she works with non-depriving families and her clients do not recover.

Like Colin, Titania was unsure where to draw the line. A client she has with an autistic brother thinks his father shows signs of autism, but that this is not necessarily genetic.

Douglas thought inheritance would be a factor. Marsha and Peter noted that autism runs in families. Brian saw that autism runs in families, but pointed out that attachment and socialization would be atypical for someone growing up in a family where carers had autism. He thought if genetics was a factor, it was a complex one and that a small number of genes could not explain something as complex as autism. Stephen did not think inheritance was a factor.

So, views ranged from conviction that autism is genetic to not seeing inheritance as a factor. I wonder if clients and therapists may find they do not have a shared understanding of autism.
Developmental

So, did the interviewees think autism was developmental? I meant, caused by the infancy care environment. However, the responses looked at development through the stages of life.

Brian (like Lucy’s response on genetics) said that deprivation can cause something which looks like autism. So he did not think development was the whole picture. He was aware of Baron-Cohen’s research on the effects of testosterone exposure in the womb (Baron-Cohen, 2000), but did not think a biological cause was proven either.

Joan’s view was also like Lucy’s answer on genetics. Joan saw a predetermined genetic pattern, followed by atypical development. She commented that research shows that autistic people’s brains mature (emotionally) later than those of ‘typical’ people (Bender, 1999). Joan’s own observations were that autistic people went through the same developmental stages as other people, but did so later in life. She also talked about some of her clients being stuck in stages of emotional development.

Colin, Douglas, Marsha and Lucy thought both nature and nurture play a part in causing autism. Lucy put this into an order where a genetic predisposition is exposed to an environment in which the brain develops; the result being a fixed neurological structure. Joan’s view could be layered with Lucy’s, giving us a genetic predisposition, followed by atypical development in infancy, leading to a fixed neurology, which then develops emotionally later in life.

I interviewed Peter on the day that news broke of the discovery of a genetic cause for autism (Cole, 2010). Peter had seen the news, but thought there was probably a developmental aspect, as well as other factors.
Stephen did not think autistic conditions were developmental – as he also rejects inheritance, he is in a position in which there is no cause, just a metaphor describing how someone is. Titania thought a client’s development would be something worth asking the clients about, so that she could understand their lives.

Development was, therefore, seen as a factor by most interviewees, including those who saw inheritance as a factor.

**Permanent**

Did the interviewees think autism was permanent? I thought this would be straightforward; nature cause, yes; nurture cause, no. However, more than one interviewee said that the effects of infancy care cannot be changed.

Stephen sees autism as a permanent metaphor for a way of being in the world. Joan’s genetic view of autism meant she saw it as permanent and Titania thought that autism was a permanent mental structure.

Lucy thought that, once established, autism was permanent, and Peter thought a permanent condition would develop without intervention in infancy, but because there was a spectrum of conditions, it would depend – by which I think he meant that some autistic conditions were permanent and others weren’t.

Brian didn’t think autism had to be permanent; he saw that, in many cases, difficulties remained, although some adults no longer fit their childhood diagnosis.

Douglas thought autistic conditions would be relatively permanent (which I think means that, even with treatment, progress is slow).
For Colin, nothing about the psyche is fixed. Whereas Marsha was the most optimistic about what psychoanalysis could achieve for adults. She thought autistic conditions were not necessarily permanent or there would be no point in therapy.

I found a real mixture of expectations, which means clients will not know what to expect from psychoanalysis. Autistic people find the unexpected difficult (Attwood, 2007, pp 64).

**Curable**

Whether autism can be cured is implied in the responses to whether or not autism is permanent. However, I wanted to compare responses on cure to stated treatment aims. I thought the questions were straightforward – curable or not curable – but the responses got straight into treatment approaches. Several interviewees thought the idea of cure was non-accepting of people, so should not be raised even if it were possible. There was also discussion of a cut-off for cure after infancy.

Lucy thought work with infants could stop autism escalating, but after infancy, cure was not possible in non-deprived children. Peter had done this type of work with infants, but did not think in terms of cure in adults because he thought fluctuation could occur. His view is that autistic traits can occur in anyone.

Titania did not think severe cases could be cured (by psychoanalysis anyway), and less severe cases could be helped, but not cured. Douglas didn’t think anything was very curable, but autism might be. Marsha thought cure was possible in adults to a degree.

Colin thought cure was the wrong question for any client, because he thinks in terms of something going wrong for the person rather than a person having something wrong with them. He thought anyone might respond with autism to particular circumstances, but did not think in terms of reversing the process. Brian helped
people accept themselves, partly by accepting them. Joan also refused the idea of cure and was positive about difference. Stephen did not think it made sense to cure a metaphor.

Given that biological causes had not been ruled out and infancy experiences were thought to have lifelong effects, I had not expected cure in adults to be thought possible. Such a spectrum of opinion again creates confusion for clients.

**Treatable**
Did the interviewees think psychotherapy was beneficial? If so, would they focus on making the client more like typical people, or help them cope with autism?

Douglas and Peter simply said treatment is useful. Brian determined what behaviour could and could not change and looked at strategies accordingly. Marsha thought autism was treatable to a degree and manageable through psychoanalysis. Lucy and Joan aim to make the client's life more manageable. Stephen sees meaningful therapy as possible, but autism remains present and he does not impose a notion of what the client should be. Titania works with the impact of autism and the client's general needs. Colin doesn't think in terms of clinical treatment.

All the interviewees thought psychotherapy of some sort had something to offer, however there were varying ideas on what this was.

**A Condition of the Psyche**
I asked the interviewees if they thought autism was a condition of the psyche. I meant psychological rather than neurological. Again, I was unclear. A couple of interviewees talked about the politics of mental health. I had anticipated that most interviewees would think autism was psychological, but I received more nuanced responses.
Marsha thought autism was of the psyche. Peter did not know where autism came from, but saw a psychological side to it. Douglas thought the idea of categorizing autism as a mental health condition was political as it used the medical model. He saw structures in place, but wanted to avoid the idea that mental life was fixed rather than a process. In stark contrast, Lucy said people were not born deprived, but once a neurological structure became fixed, the result could not be defined as a mental health condition.

Stephen said there was no such thing as the psyche. Brian hadn’t thought in these terms, but thought that people with autism were not that different from other people in terms of their feelings, and were not in their own world.

Colin said everything was psychological, even a broken leg would have a psychological impact. Joan thought any psychological issues autistic people had were due to them not being supported to cope with autism. Which is similar to Titania’s focus on tackling the effects of physical conditions, not the conditions themselves. She did not know if autism was physical.

There was a wide range of opinion on whether or not the interviewees were treating a psychological condition or something else with psychological implications.

A Condition of the Brain or Body
With no consensus on the psyche, what about the flesh? Some researchers think that autism is about brain functioning (Frith, 1989, pp 77), while others look at the body with ideas about vaccines (e.g. Wakefield, 2004, pp 12). These ideas are not mutually exclusive.

Joan said autism was a brain condition. Lucy saw a fixed structure developing in the brain. Douglas thought cognitive processing differences were involved. Brian said autism was centred in the brain, but that brain and body connect. Marsha, Peter,
Stephen and Titania all thought autism was a condition of both the brain and body. Stephen emphasized that the brain and body (and psyche) are a single entity that, with environment, create the person. Colin thought some conditions were bodily manifestations of psychological issues but not autism, nor did he think autism was a brain condition.

So, the interviewees made no clear distinction between cognitive processing and physical health.

**Spectrum**

Some people see distinct conditions under the autism umbrella, while others see a spectrum of related conditions (Feinstein, 2010, pp 169). Autism spans people who do not use speech to communicate to those with professional careers.

I wanted to know if the interviewees’ approach was influenced by whether or not they thought their client had a condition related to any available case studies. I also wondered if there could be a muddle. Some mental health conditions look like autism, and I might find the view that some autistic conditions were linked, but others were unrelated mental health issues.

The existence of a spectrum was the overwhelming response. The new edition of the Diagnostic and Statistical Manual of Mental Disorders, (DSM V), recognises this consensus among practitioners and will describe variations of autism. Conditions which now have their own name will all be called autism (see Appendix K).

Only Marsha thought that there were distinct conditions. Peter thought that, at the more ‘server’ end of the spectrum, there was possibly something distinct as some people were more apparently affected than others, but he had no experience of this end of the spectrum. I assume he means experience with adults.
Colin thought that if a psychological structure was in place, it was either there or not, and ‘degrees of autism’ was like saying someone could be a ‘little psychotic’. He saw a continuum of possibilities (levels of wellness) along which someone might move. All these possibilities would definitely have the structure present – a spectrum?

Brian stands apart from many of his colleagues in his multi-disciplinary team in seeing a spectrum. Brian sees the conditions have more in common than they have differences.

Stephen cited both Baron-Cohen and the University of Sunderland (see Appendices M & L) in saying there was a spectrum. This is research into the effects of testosterone exposure in the womb and diet and autism respectively. Stephen encounters different ideas on autism from his multi-disciplinary NHS team and from clients. I was surprised by his view, given that Stephen sees autism as a metaphor.

Lucy sees spectrums, with each autistic person having a different degree of ability across a range of tasks. These variously able people are categorized into conditions and these conditions are related to each other. Douglas took a similar view of a wide spectrum, saying that Meltzer would put Obsessive Compulsive Disorder on the autistic spectrum. Joan said there was a spectrum and talked about a joint workshop covering autism and Attention Deficit Hyperactivity Disorder. We have ended up with a web, which joins not just more and less apparent forms of autism, but also other cognitive processing disabilities and some mental health conditions.

Establishing the Therapeutic Alliance

Is It Important To Know?

Did the interviewees want to know if a client had autism? I wondered if they would be so concerned to treat people as individuals that information about an autistic person’s
communication needs might be lost. I was surprised that even those interviewees with years of experience in autism were cautious of asking clients if they were autistic, wanting to be sensitive. Several people pointed out that they don’t ask about any condition. This might be understandable for something like cancer, but for autism, it could mean that communication needs are hidden from the therapist. Opinions ranged from strongly against knowing to seeing knowing as essential.

Joan thought it was useful to know, but not necessary. Marsha thought it would be good to know as it would guide the work. Lucy said knowing was important and she was alert to the signs. Brian thinks it’s important to know what someone’s difficulties are as these can be in important areas of life. Titania said it was something that needed to be acknowledged.

Peter thinks transference would reveal autistic traits or early bonding issues. I was unclear how he would tell which was which. He may not use the word autism with the client because he cannot diagnose autism. Douglas felt it was important to be able to consider autism as a possible way of understanding the client and sees autistic traits in himself. Stephen saw pros and cons of knowing. Colin wants to form his own view of someone’s abilities.

Joan, Brian (as people go to him for diagnosis) and, to an extent, Lucy knew their clients had autism from their referral. No one routinely asked clients about autism at the start of therapy. Douglas spoke for many, saying he wouldn’t ask about any condition. Titania thought it would be helpful to discuss diagnosis if raised by the client.

So clients have to raise their diagnosis and may find they are being treated by people who chose not to consider autism’s implications, such as communication needs.
Response If The Client Disclosed at the Start of Treatment

So how would the interviewees respond to clients disclosing autism at the start of therapy? Responses ranged from taking the information in their stride, to assessing whether the clients should be referred elsewhere.

Marsha would treat the information as she would for other disabilities, simply bearing it in mind. Joan would be positive and matter-of-fact, as people with autistic conditions are often misunderstood. Both Lucy and Brian would ask for more information to check their understanding. Lucy also said the client might want to check her understanding. Titania would find out as much as she could by asking how long they’d had the diagnosis and what treatments they’d tried.

Colin saw the disclosure along the same lines as someone saying they had mental health issues, like bi-polar, and wanted to find out what it meant for the client, without relying on his own assumptions. Stephen would ask how the client discovered their autism and what it meant to them – their story of their life.

Peter would explore the issue with the client. He feels that labels shut down meaning. I thought this was a shame as it could come across to the client as not being believed, and not having a term to use to discuss their condition and open up understanding. I wondered if cancer would be called a label.

Douglas would ask what the client meant by autism and would refer the client elsewhere if his counter-transference suggested to him the therapy wasn’t working. Douglas feels able to work with those with the psychological barriers Tustin describes (Tustin, 1986), which he says could equally be seen as psychosis – the two can overlap. But how to tell what type of autism a client has?

I was concerned by some of these responses. I had asked about disclosure, not the client wondering if they have autism. At the sensitive point of disclosure, clients
were often expected to respond to questions on the validity of their diagnosis. The client may feel they are not believed, which is confusing for someone whose condition means they are literal and unable to understand that other people have different thoughts to their own (Attwood, 2007, pp 46). They would also have to respond to autism discussed as metaphor, and autistic people can find metaphor hard to understand (Deudney, 2003, pp 4). The situation compares badly with that of other conditions (ironically those where communication is not an issue). I suspect few psychoanalysts would ask clients who said they had cancer what made them think that and who exactly had diagnosed them.

Sometimes clients were asked to articulate what they wanted from psychoanalysis. While the psychoanalysts clearly wanted to ensure they provided what the client needed, autistic people have a limited executive function (Appendix L) and may not be able to plan ahead and respond to this question as other clients would.

*Working with Clients*

*Known Experience of Autism*

This question explored the interviewees’ experience of autism. Lucy and Joan had many years’ experience. Brian’s role as a psychiatrist means he mainly works with children with autistic conditions. He has a little experience working as a psychotherapist with adults. Douglas, Marsha and Stephen each have one autistic client.

Peter is working with someone whose diagnosis he doubts, and others he thinks have Tustinian barriers (Tustin, 1986). Titania has a client whose brother is a young adult with autism. Colin had not knowingly worked with an autistic client.

I found that experience influenced treatment approaches.
Recognition

Autism is hidden and often confused with mental health conditions such as Obsessive Compulsive Disorder or Schizophrenia (see Appendix L). There are behaviours which indicate autism is present. How would the interviewees recognise autism? Several people referred to the way in which the client related to the therapist or spoke about relationships. I was amazed how few people referred to eye contact or body language. This could be a lack of knowledge that these things are signs, the possibility that they are also signs of other conditions or the fact that communication in therapy is unlike communication in the rest of life, so such signs lose their value. I was sure some clients were not being seen for what they were.

For some interviewees, autism was highlighted at referral. Marsha had her autistic client referred as autistic, but thinks difficulties of attachment would highlight the issue anyway.

Douglas would use his own feelings; recognizing autism by an extreme difficulty in making effective contact with the client and having no sense of what was going on for the client emotionally. He would also note if a client had repetitive and predictable behaviour.

Peter said it was something the therapist would notice in listening to the client talk about relationships outside therapy, as well as how the client related in therapy. Stephen had identified his autistic client a couple of years into therapy as having autism through the way the client reported repeating unhelpful ways of relating to others. In the light of this work, Stephen realises he might have missed other cases in the past.

Lucy is referred clients with autism, but looking back, realises that, before she was familiar with autism, she probably missed some cases that had not been referred to her as autistic. For Lucy, the signs are having other family members with autistic
conditions, as well as the client struggling in relationships and being overwhelmed by their own feelings.

Colin had not knowingly worked with anyone with autism, and did not know if he would recognise autistic conditions, as he would not be thinking along these lines. Titania made a similar point that autism is not a category psychoanalysts look for. She thought how the client formed relationships and their theory of mind (Appendix L) would be signs of autism. However, she could easily call autism something else; if she were to work with someone who found it hard to understand other people’s minds, it would look like psychosis.

Brian asks question to diagnose autism as part of his job and finds that not everyone who thinks they have autism meets the criteria. Whereas, less clinically, Joan says her experience enables her to spot autistic people easily everywhere she goes.

Not all the interviewees were confident they could recognise autism. Therefore, unidentified, the particular needs of autistic people might not be addressed.

**Had The Interviewees Ever Suspected A Client Was Autistic?**

Autism is invisible; many people don’t know they have it, or they do know and hide it. Psychoanalysts need to be aware that a client may have autism.

This was Stephen’s experience. He spotted that a client fitted the description of autism and was able to raise this with the client and work through the implications. Peter had spotted an issue in how one of his clients was relating and just kept working without raising the possibility of autism because, psychoanalytically, it’s not a term he uses. (This is not the client Peter mentions who disclosed herself to Peter as autistic).
Brian is currently providing psychotherapy to someone who did not meet the diagnostic criteria, but shows signs of autism.

Joan has had suspicions but is careful about raising them with clients.

Lucy has suspected autism in some patients, but recognised that she was not qualified to make a diagnosis, so just kept it in mind.

Colin, Douglas, Marsha and Titania had not had suspicions.

The interviewees had differing abilities in spotting autism and this question showed how this had worked in practice.

Do Clients Disclose Autism During Therapy?
I wondered if, once some trust had been established, clients would disclose autism. This was rarely the case, although several interviewees talked about people finding out they had autism or considering tests during the time they were in therapy.

Joan was pleased when disclosure occurred from one young man; it was a breakthrough in getting over the stigma (she had held back from suggesting the idea to him).

Peter had experienced disclosure with his autistic client. Brian finds disclosure common due to the nature of his work and the fact that autism is in the media and so in people’s minds. Titania also said that, due to public awareness, it was something people were asking themselves, almost to the extent of a fashion now that diagnosis is possible for those at the less apparent end of the spectrum. I felt it was unfortunate for something as misunderstood as autism to be degraded to the level of ‘fashion’ in popular opinion. In the same way dyslexia is written off as middle class for thick, autism has become middle class for rude (Sainsbury, 2009, pp 120).
Lucy finds that clients can come to suspect they have autism during therapy and Douglas had an established client become diagnosed by another service. However, Colin, Stephen and Marsha had not experienced disclosure during their work.

There was some experience of clients disclosing autism with varying responses.

**Raised Six Months Into Therapy**

I wondered if the interviewees’ responses to disclosure would be different once the therapy was established. Perhaps having formed a view of the client’s communication, experience would temper assumption.

Peter spoke about a client disclosing earlier on in therapy. Joan would simply take the information on board. Colin would show interest.

Lucy would be surprised that she had not spotted it earlier. She would look at the context in which disclosure was made. Some people have been told by friends they are autistic when they might just have challenging behaviour. Similarly, Marsha thinks that autism would have become apparent by six months, so the issue would be why the client mentioned it at this point.

Brian would like to know what it meant to the client. Titania would like to know what exactly the diagnosis was and what it means for the client, and whether they hadn’t mentioned it before because it was difficult for them and whether the diagnosis was useful for them. Douglas wants the client to say what diagnosis means for them and where it came from, and what the client’s relationship with the word is, and would ask himself if the client is mentioning autism at this stage as a psychological defence. If he could not understand the client’s condition, he would signpost the client elsewhere. Stephen would work with what it meant for the client and the implications for the therapy.
Some interviewees doubted autism was the issue and questioned the feelings of clients who find communicating feelings hard. After which, the client might have to go through the whole thing again when referred elsewhere.

Treatment Aims
Would views on autism’s nature determine treatment aims? No.

Colin would have the same aim as for other clients, enabling people to be as alive as possible. Peter also has the same aims as for other clients; to establish a relationship through which the client can learn to live more fully and with more insight.

Stephen aims to help people feel comfortable being themselves; for autistic people, he also aims to help people feel more comfortable socially. Joan focused on empowering clients with strategies so they could achieve what they wanted to achieve. Solutions were often unusual. Similarly, Titania would start with the issue which brought someone to psychoanalysis.

Lucy finds integrating the diagnosis with a sense of self is often an issue, as is disclosure in the client’s life outside therapy. Douglas would try to build emotional contact slowly and carefully, so the client developed the capacity to think about their feelings and those of others. Brian tries to develop the client’s interest in exploring their internal world and using imagination to cope with difficulties. Marsha would consider the degree of autism and work with other professionals with whom the client was in contact.

The interviewees have a wide variety of aims, from accepting that autistic behaviour will not change to facilitating the type of thinking autistic people find ‘difficult’. Again, variety makes it hard for clients to know what to expect from therapy.
Communication

The NAS recommends that health professionals working with autistic people: be literal; use simple language; use short sentences; avoid idiom; use direct requests like ‘Please stand up’, not ‘Can you stand up?’, to which the literal answer is ‘Yes’ while remaining seated; check the client’s understanding; avoid conveying meaning through body language as the message may not be received; and ask for information needed as it may not be volunteered (Deudney, 2003, pp 4). I wondered what approaches the interviewees used.

Lucy avoids waffle, thinks through what to say before speaking and uses short sentences. She is careful to be clear and concrete and checks what level of metaphor the client understands. Lucy emphasized the need for sensitivity, pointing out that, unlike many other conditions, autism affects who someone is, not just how they are. She is alert to the possibility of misunderstanding in verbal and non-verbal communication and knows that her gestures will not be understood. She accepts that some clients will avoid eye contact and is aware that their lack of body language hides their level of stress. Lucy is careful using counter-transference so work isn’t sidetracked by what she thinks the client’s issues are. Lucy facilitates the client’s involvement, asking questions that provoke thought rather than waiting for the client to put their feelings into words on their own.

Joan is literal and sets clear boundaries. Joan avoids being critical and affirms progress, even when things go wrong, because autistic people face many challenges and miss out on affirmation. Autistic people often have special interests. Joan uses these interests as analogies when getting a point across. Joan checks the client’s understanding and is cautious of relying on the client’s body language. She educates clients on the meaning of other people’s body language.

Brian’s approach depends on the severity of the client’s communication issues. He adjusts his speech to the client’s ability to speak and hear information. Brian avoids
topics clients may not feel confident talking about, like ‘what do you think?’ questions, and instead asks about topics about which the client will be more relaxed.

Stephen’s autistic client is articulate, using language in a linear way. Stephen tunes into how the client speaks and then checks his understanding of the client with the client. Stephen finds different ways to explain things if what he has said is not understood.

Titania was aware the client could feel unsettled by her interventions. She used the example of Christopher Boone, hero of The Curious Incident of the Dog in the Night-Time, who receives typical communication badly (metaphor is seen as lying, mentioning something harmless like the colour yellow provokes disgust (Haddon, 2004, pp 67)).

Colin would use sensitivity to avoid driving someone mad by asking them to do what they could not do (reflect on their thoughts and feelings). Marsha thought communication would depend on what could be built over time. Peter mentioned containing the client’s anxiety so that issues could be explored but did not say how this could be done. Douglas did not have an approach specific to autism, but realised it would take time to establish communication.

While some interviewees had considerable expertise, others were only aware that a different approach might be needed.

**Technique**

I anticipated that technique would vary with the interviewee’s understanding of and experience of autism, and with orientation. Approaches were very varied. Reasons for adopting the approaches ranged from applying an orientation, which in some cases meant having no defined technique at all, to trial and error. Many interviewees wanted to treat clients as individuals, which may be necessary and sounds laudable,
but I fear that this could mean treating an autistic person as if they were not autistic, and then misinterpreting the results as, for example, the client avoiding difficult issues.

Both Titania and Colin responded differently to every client. Peter took a firmer, purist line, keeping with his usual technique to break through the difficulty in relating. He would notice ‘hidden messages’ in not turning up to sessions (it could be poor executive function). Peter tries to engage in playfulness, like his work with infants, to challenge fixed beliefs.

Stephen’s autistic client knew about psychoanalysis, but in applying the ideas to himself, he got stuck, so Stephen adapted his approach.

Marsha uses a completely different technique and recognises that each autistic client has specific communication issues. Marsha has used painting and music to get past a client’s silence. She and the client found the work hard, but easier than sitting in silence.

Lucy has adapted her technique for a range of clients with particular needs; she is more present (not the blank screen – see Appendix L) and concrete and aware of the client’s external as well as their internal world. Some issues clients raised needed to be taken at face value and practical responses could be relevant. Lucy finds that some clients need to discuss autism itself, and be educated about what it means. Lucy only uses transference in long-term work when the therapeutic alliance is really established. She looks at clients’ internal worlds in an adapted way, as autistic people may be less reflective or take time to reflect, or to become reflective. Without such reflection, interventions make no sense.

Joan found classic psychoanalysis did not work for autistic clients. She adapted the basic principles of lots of therapies, underpinning everything with a strong
therapeutic alliance. Joan’s understanding of her clients includes impressions of their unconscious feelings, but she does not interpret these ideas to her clients, as it would confuse them.

Joan asks ‘what do you think they think?’ questions to check a client’s understanding of others’ minds. She does not expect clients to know their own feelings or those of others. Joan assumes no shared meaning and is careful of misinterpreting the client’s feelings about, for example, controlling parents who may provide the client’s missing executive function (Appendix L). Joan also uses information from the client’s family or colleagues, as clients may have no sense of what is important to tell her; she is careful not to see this as denial.

Joan uses group work and meets clients in cafés to observe clients’ social interaction. Group members give each other feedback on their social skills. One-to-one, Joan offers feedback, which is clear and sensitive. Calling therapy ‘coaching’ helps clients accept that they need help. The real interactions stop clients understanding the theory of social interaction, but not changing in practice. This was a problem that Stephen had also noticed.

Joan facilitates participation, for example, buying the books for the discussion group as the members lack executive function. She accepts different learning styles and educational backgrounds – not assuming there will be common cultural references. Joan is patient as clients learn to express themselves.

Joan challenges a client’s fixed irrational ideas about others, such as: ‘the staff at my care home don’t want me to be fashionable.’ She helps clients understand people, for example, by looking at character motivation in a novel.

Brian recognises that autistic clients are more likely to depend on their families, so he engages the families. Adult autistics might behave more like adolescents and be
accompanied to therapy by a parent. This is similar to the experience of Joan and Lucy. Brian uses his psychoanalytic understanding to help clients with autism think. This is different from simply engaging in psychoanalysis.

Approaches ranged from rethinking psychoanalysis entirely to sticking to traditional techniques; even when the interviewees knew of evidence that autism was not a psychological condition.

Results
I expected that work would stall sometimes and misunderstandings occur, but made few assumptions about results as I did not know what was being tried.

Joan was realistic about what short-term work can achieve (most of her clients cannot get funding for long-term work). She saw small changes making a difference to both clients and their families, but is never sure whether or not what she tries will work.

For Lucy, the results were seeing people able to take on roles they hadn’t succeeded in before, such as coping better as a parent of a child with autism because the client had accepted their own autism.

Peter expected to see more eye contact and the client staying in connection, and reported that his client had stayed in therapy for some time and that she is laughing more, is less rigid and more playful.

Brian finds that clients respond well to his adjustments. Marsha said that transference can be more difficult with autistic clients. Douglas’ client suffers episodes of despair; over the years he has been a gentle constant relationship in her life, providing containment and shape to her experience. His client comes less often now, but returns when she needs to.
Stephen’s work with an autistic client resulted in the client trying different behaviour and greater self-reflection for Stephen. For Titania, results would depend, not on her approach, but on the client’s response, as autistic people vary enormously. Colin had no expectations having not had an autistic client.

The results stated do not prove the advantage of any particular technique, but show the outcome of the approaches adopted.

**Impressions**
With no training on autistic adults, few published case studies and a variety of ideas on what autism is and how to treat it, it is probable that psychoanalysts will not know how to handle autistic clients and clients will not know what to expect from psychoanalysis. It is necessary to clear the smoke from our eyes, and look at the impact of such confusion on the client. This I do in the next section.
Part Two – Mirror, Mirror Off The Wall

‘...they were sawn in two ... – of whom the world was not worthy.

_Hebrews 11:37_

‘Harry: What I’m saying is – and this is not a come-on in any way, shape or form – is that men and women can't be friends, because the sex part always gets in the way’ (Ephron, 1989). So says Harry Burns in the film _When Harry Met Sally_. Early in his career, Freud had feared that the work of psychoanalysis could never happen as, one after another, his patients fell in love with him (Freud, 1911-13, pp 165). The sex part was getting in the way. Just as Harry falls in love with Sally and the sex part offers them something more than friendship, so Freud finds that transference can lead to something more than stalled analysis.

Autistic adults have something in the way of their psychoanalysis. Time and again, the interviewees mentioned problems with transference and counter-transference. Can this be resolved or will transference itself always get in the way?

As in the film _When Harry met Sally_, a number of people with couches have something to say. I included here summaries of each interview in turn as each one raised important issues: transference and other issues along the way.

**The Red Fabric Couch – Brian**

Oddly for a psychiatrist, Brian did not know if he thought autism was psychological. Brian saw that development is not the whole picture, with deprivation causing something that looks like autism. Brian had laid some science over his training. He was clear that autism is a condition of the brain and referred to research on the effect of testosterone exposure in the womb on brain development (Baron-Cohen, 2000) – without being wholly convinced that autism has a biological cause either. His conclusion that inheritance is social as well as genetic is interesting, and this point
was also made by other interviewees walking the nature/nurture tightrope. Brian was careful not to assume that he and clients who raised the issue of autism had a shared understanding of autism.

Brian diagnoses autism. It is not within the scope of this paper to discuss the pros and cons of the various diagnostic tests or the issues around what types of professionals have what types of training to administer these tests (see Appendix K). Suffice it to say, they all involve a questioning process, which is tricky when working with those who find it hard to communicate. Sometimes family members are questioned, which is also problematic as inherited conditions can be present in several family members.

Brian sees that childhood diagnoses may not fit later in life, so he thinks autism is not necessarily permanent and questions diagnostic reliability. My view is that someone does not grow out of their brain wiring (Frith, 1989, pp 77), any more than people grew out of being left-handed.

When a client does not meet the diagnostic criteria, Brian may still think that the ‘idea’ of autism would be useful to them. I felt that Brian saw shades of grey beyond the conditions recognised on the autistic spectrum. Deciding where the spectrum ends is tricky.

Brian also commented that clients could be ‘prone’ to autism. My feeling for what Brian was saying was not that autism was, in his view, fluctuating, but that at heart he saw it as psychological more than biological – a predisposition to the condition – being more like depression than bronchitis.

Although Brian does not see autism as permanent, he rejects the idea of cure. His approach is to accept people and helping them accept themselves. Useful work, if illogical. I think Brian is wise to reject fixed ideas about treatment based on
diagnosis. In a former role, Brian noticed that what clients were diagnosed with dictated treatment. For autistic clients, there was little focus on working with emotions. Brian recognises the emotional difficulties autistic people can have and uses both drugs and psychotherapy.

Brian aims to understand a client’s difficulties, and tries to develop their interest in exploring their internal world, using psychoanalytic ideas to help people think without actually working through analysis.

Brian adjusts his speech to a client’s ability to speak and hear and avoids asking for the client’s thoughts, opting for topics the client will be more confident talking about. This approach builds rapport, but does not address difficult issues and makes me wonder if key questions have not been asked at diagnosis.

The Black Leather Couch – Colin

I was keen to include an interviewee with no experience of autism to see how they might respond in principle. I imagine that autistic people find themselves in the offices of such therapists. There are 580,000 people in the UK diagnosed as autistic (BBC Health website checked 21 August 2010). Under diagnosis is an issue, especially for women (Attwood, 2007, pp 46). Any psychoanalyst might, therefore, encounter hidden autism.

Colin has many years’ experience with typical clients, but has never knowingly worked with an autistic client and has had no training on autism. Colin bravely volunteered to speak from this point of view. Much of what he said is what one might expect to hear – a traditional psychoanalytic stance. These responses enable me to talk about some of my concerns about psychoanalysis and autism.

Colin’s view of autism is ‘text book psychoanalysis’ – he gave a detailed description of the bonding problem he thought causes autism (Feinstein, 2010, pp 68). In
practical matters, Colin wished to avoid pathologising the client; he thought in terms of something going wrong for the client, not there being something wrong with the client. Although Colin thought of autism as a description of a state of mind, which need not be permanent, he steered away from the idea of cure. Although I don’t think cure is possible, I question Colin’s approach, which leaves people with a condition he thinks is not permanent without a cure, because talk of cure would imply a judgment on the client – the client cannot chose an outcome without discussion.

Colin was uncertain where the boundary lay between a psychological condition and such a condition’s psychological effects. This highlights the problem caused by the nature/nurture, issue/impact, chicken/egg debate around autism.

Colin would not simply apply classic psychoanalytic technique with any client. Classically, analysts remain silent, allowing the client to project feelings they have towards other people onto the therapist (Aron and Mitchell, 1999, pp 98). If a client did not respond to his silence by speaking, Colin finds it cruel not to speak himself.

Colin’s technique is to respond flexibly to each client. He thinks he is being sensitive, but by relying on his sense of attunement to determine how to respond, he faces the difficulty of becoming attuned with people who look like everyone else but communicate differently. Colin realises he might not recognise autism as he wouldn’t have autism in mind. Further, he wants to know as little as possible about his clients before beginning work so that he can form his own opinions. This sounds fair, but the therapy may be at cross purposes.

If Colin were aware a client was autistic, he would avoid causing the client frustration by asking them to reflect on their thoughts, which they might not be able to do. He drew an analogy with working with psychotic clients who also find it hard to think about their thinking. This approach is hardly surprising, as psychoanalysis typically sees autism as a form of psychosis (Tustin, 1995). Colin did think it would be
possible to facilitate some capacity for thoughtfulness, within limits. He recognised that this would take time and mistakes would be inevitable.

Colin talked of using paths of indirection, instead of simply asking someone to do something they can’t do. Joan’s use of fictional characters is an indirect way of learning about people’s motives, but I wonder if Colin is talking about one topic to open up thinking on an unrelated topic – which might confuse an autistic person, as autistic people find abstraction difficult (Attwood, 2007, pp 81). Colin would also focus on more practical matters, such as symptom alleviation and finding solutions to life’s challenges.

To avoid labels, Colin was reluctant to discuss autism with clients. In his interview, he used the phrases ‘under that sign of autistic, designated autistic and so-called autistic.’ If a client says to Colin that they are autistic and Colin won’t use the word autism, this leaves the clients unable to discuss their needs. Autistic people struggle to make themselves understood and are trying to describe having an invisible, misunderstood condition. The client is talking to someone they hope will help – the therapist – but who disallows the word for their condition. The client is disempowered. It is obvious when someone is blind, we know what being blind means and it would still be hard not to use the word ‘blind’. The impact of not using the word ‘autism’ is even greater. When dealing with label avoiders who bar an autistic client from using language which pins anything down, without being accused of limiting their view of themselves, an autistic person receives the message that their understanding of their experience is not valid and their communication of their experience is yet another failed communication.

The White Linen Couch – Douglas
Douglas sees autism as Tustinian barriers any adult can have (Tustin, 1986). He would not work with clients outside this definition. This raises the issue of determining what type of autism someone has. Douglas has clients who he
identified as having Tustinian barriers, but not what he calls ‘full-blown autism’, by which he meant someone who needs help to contact their environment.

Douglas placed autism on a spectrum of mental health conditions in the way psychiatrists typically do. He cited Meltzer who he says would put Obsessive Compulsive Disorder on same spectrum as autism. The alternative view is that obsessive behaviour is an indication of autism (Attwood, 2007, pp 138).

Douglas has worked with a woman who was diagnosed by other professionals as having Obsessive Compulsive Disorder, and then, during her therapy with Douglas, had her diagnosis changed by them to autism. It is very common for autism to be misdiagnosed as Obsessive Compulsive Disorder – especially for women (Attwood, 2007, pp 138). Of course, this is no help to psychoanalysts who have been lead to bark up the wrong tree by their professional cousins. Douglas was aware of his client’s contact with other professionals, but his work was independent of them.

Douglas would respond to a disclosure of autism at the start of therapy by looking at the client’s understanding of autism and, using counter-transference, assess their psychological makeup. But Douglas would recognise autism through an extreme difficulty making effective contact with the client, and having little sense of what’s going on for them emotionally, i.e. counter-transference not working. He would also note the client’s difficulty in expressing what’s going on for them emotionally, and he recognises that there may appear to be contact but that this could be illusory.

Douglas thinks it’s helpful to be able to consider autism, but that there may be better ways of thinking about a client’s mental state. He drew a fuzzy boundary around autism, seeing that there are autistic traits in himself and in all of us. I wonder if it would be helpful to say to an autistic person that we are all a little bit like that. We don’t say to someone blind that we are a bit like that too – Joan talks of autistic
people being a different type of other. This would be something we have not all experienced, and autistic people’s experience is discredited if this is not recognised.

Having made an assessment, if Douglas felt he could not help, he would refer the client elsewhere. Douglas was clear about the extent of his competence with autism, mentioning a different type of work (social care) done by a relative of his. Knowing his limits might mean referring a client on just at the point they had dared to come to therapy.

If disclosure was made at six months, Douglas would have a different response. This was something I had anticipated from all the interviewees as, once a therapist knows a client is autistic, they may respond differently. Douglas would ask the client what they think autism is and if this is a diagnosis someone else has given them. This may be received by the client as doubting the validity of the diagnosis, which is not helpful for someone with a hidden misunderstood communication difficulty.

Douglas would be interested in the client’s relationship with the word autism. I wonder if autistic people have relationships with words, as this is an abstract idea. Douglas wondered if disclosure at six months was a defence. Perhaps in wondering this, he is introducing a barrier to the work, as the autistic person may not be able to relate to non-literal communication (Deudney, 2003, pp 4).

Douglas’ aim with an autistic client is to develop, slowly and carefully, emotional contact and the client’s ability to think about emotional life. As with other clients, he tailors communication using intuition and counter-transference. Using a process that is difficult to use with autistic people to help them do something they find difficult is likely to be a slow process indeed.

In fact Douglas’ autistic client has episodes of despair, and Douglas has been able to provide containment over the years. His final comment that what worked was that
the client knew Douglas liked her was perhaps a hangover from Douglas’ humanistic past. Given what Joan says about autistic people missing out on affirmation, this probably matters a lot.

**The Burgundy Studded Couch – Joan**

In the film *When Harry Met Sally*, Sally points out to Harry that communication can be faked:

‘Sally: ...’Most women at one time or another have faked it.’

Harry: ‘Well they haven’t faked it with me.’

‘...

Sally: ‘... all men are sure it never happened to them and ... most women at one time or another have done it, so you do the math.’

Harry: ‘You don’t think that I could tell the difference?’

Sally: ‘No.’

Harry: ‘Get outta here!’

[Sally begins to fake an orgasm]

Harry: ‘Are you OK?’

[Sally continues very audibly, attracting the attention of nearly every customer in the cafe. Afterwards, she returns to eating her dessert]

*Older Woman Customer [to waiter]: ‘I’ll have what she’s having’* (Ephron, 1989).

Joan spoke about miscommunication with autistic clients. If her clients were in Sally’s café, they would watch Sally, order the ice cream Sally had and scream when they ate it. They try to fit in by copying others, without understanding the implications. They fake ‘doing therapy’. The mask is gauche but not seen through, as the temptation for psychoanalysts is to analyse the fake behaviour and this disrupts transferences. An example is Gunilla Gerland, an autistic woman who deliberately cried in therapy because that’s what one is expected to do (Gerland, 1997, pp 147). She did this, not to follow convention like girls screaming at the
Beatles because it had become customary (Frontani, 2007, pp 76), but as an outsider trying to become real by doing what others do.

For Joan, autism describes a complex difference that varies from one autistic person to another. Joan said an autistic person’s brain will develop to a different blueprint, with emotional capacity – to the extent it can develop – developing later (Bender, 1999). As well as brains that mature later, Joan said autistic people needed to accumulate experience to learn intellectually what typical people learn socially, with fewer experiences.

Joan had observed that autistic people go through the same developmental stages as typical people, only later, and that there is much scope for autistic people getting stuck. Therefore, adults have lifestyles more like a typical adolescent. Other interviewees recognised this. Interpreting this behaviour as regression would be counter-productive.

Joan commented that progress claimed by psychoanalysts could simply be the autistic client growing up. Lucy talked about working with families with autism in several generations; these families also displayed behaviour it would be misguided to interpret psychoanalytically. Only cautious assessment of the success of psychoanalysis for autistic people is possible.

I was surprised by Joan’s comment that it was useful to know her clients were autistic, but not necessary. Her response to disclosure is straightforward; clients are believed and affirmed without the inquisitorial approach other interviewees took to clarify their own understanding. Given Joan’s experience, this may not be necessary and allows the client’s concerns to be central. On the other hand, Joan is careful of the client’s feelings when she suspects autism is present. She allows the idea to inform her work without rushing to tell the client.
Joan understood how to communicate with autistic clients, which many of the other interviewees lacked in their well-intentioned attempt to sense the needs of individuals using typical communication. Joan has observed that autistic clients do have unconscious motivations and use behaviour like projection, but that they also lack the self awareness for an interpretation of the projection to be useful (projection in this context is having feelings about one person, but seeing them in someone else). This means that Joan’s understanding of the client is psychoanalytically informed, but her communication with the client is more literal.

Joan’s care not to misinterpret a client’s feelings about a bossy parent who is providing the executive function for the adult client avoids an interesting twist in autism’s history of parent-blaming (see views of Bettelheim in (Feinstein, 2010, pp 44)).

Joan had examples of how therapy can give a false sense of an autistic client’s life. Joan involves client’s family members or colleagues to ensure she has an accurate idea of the client’s life. She also observes how her clients behave in real social interaction. She started a group therapy book club, which sounds like a lot of fun (as the woman observing Sally said: ‘I’ll have what she’s having’).

Joan helps her clients live with autism, which she celebrates as a difference. This is very much part of the zeitgeist and there is a growing autism pride movement (Anonymous on Wikipedia, seen 24.07.10).

When therapy comes to an end, Joan is careful about the client’s feelings. Autistic people can have very restricted social support and may have become dependent on her and lack the mental flexibility to think about life after therapy. She also helps families communicate better with their autistic members. However, she is careful about confidentiality when involving clients’ families.
The Orange Sixties Retro Couch – Lucy

Lucy was a surprise; she has worked with autistic people for years and is an NAS-listed therapist but has a view on what autism is – which is not shared by many within the NAS, where infanthood attachment as a cause is discredited (see Dr Gould: Appendix A). While I disagree with Lucy’s view, the way she draws on psychoanalysis, other techniques and her experience to develop her method has resulted in a model for what psychoanalysis can look like when it works for autistic people.

Lucy’s training did not cover autism and she now wonders if some of the case studies in her training were undiagnosed autistics adults being treated as typical people. An interesting point; I wonder how much psychoanalytic theory is based on observing people with hidden differences and applying the findings to the general population.

Lucy drew an analogy with psychoanalysis for autistic people today being where psychoanalysis was in treating homosexuals 30 years ago. Such a view of treating homosexuals in psychoanalysis is discussed by Cleese et al (Cleese, 1988, pp 249). I agree with Lucy in seeing the similarity. In the same way that psychoanalysis then saw homosexuals as psychologically ‘damaged’ and used misguided treatment approaches (such as ‘cure’, Cleese et al, 1998, pp 250); autistic people now are faced with psychoanalysts who may see them as damaged by their infanthood bonding, rather than different in their cognitive processing (Feinstein, 2010, pp 58), and who use inappropriate treatment approaches. An example would be Marsha, who believes cure is possible despite autism now being widely recognised as a congenital condition (Frith, 1989).

Lucy had her own take on the relationships between genetics and development, seeing a genetic predisposition rather than a straightforward cause. More like a probability that one will develop heart disease than be born with blue eyes. Lucy was
also influenced by Tustin’s idea that all children go through an autistic stage (Tustin, 1986, pp 59). Lucy thought that some got stuck; presumably Lucy would say the ones who get stuck are those with a predisposition who have been exposed to certain experiences. Lucy did not see development as causal in all cases; however, she mentioned research on deprived Romanian orphans and how some of their behaviour was reversible (see Frith, 1989, pp 50). She commented that her own childhood hospitalization resulted in autistic behaviours, but she does not see herself as autistic, and that she now works with families who have not deprived their children and these children’s behaviours are permanent. This highlights the need for clarity on what autism is and what it is not.

However, Lucy did think that intense work of subtle attunement with very young infants could stop autism escalating, or divert it, because our neurology is not fixed at birth. Potentialities are fixed and attachments are still forming. Lucy said that people are not born mentally ill or deprived. But I wonder how someone with different potentiality forms attachments in infancy and in later life, in any circumstances. Lucy said that once brain wiring had become fixed in infancy, there was a structural difference in the brain and that autism was not, therefore, a psychological condition. She works with clients who have struggled with how to cope socially for years, and need strategies to help them live with a condition which she recognised is not going to go away.

Lucy saw the potential for confusion between autism and mental health conditions – there could be dual diagnosis such as depression and autism – and a lot of the effects of living with autism are very similar to some mental health problems.

When working with autistic clients, Lucy is aware that her own body language will not be understood. This was a useful addition to comments made by herself and other interviewees that the autistic person’s body language will be misleading to the therapist.
Lucy’s technique when working with an autistic person is to be more present and not rely on the client projecting onto a blank screen. In longer term work, transference and counter-transference are used. Lucy looks at the client’s internal world in an adapted way. She uses her experience of childhood deprivation to do this, although she recognises her clients were not deprived. She also needs a greater degree of stillness in herself and presence to the client to pick up on the client’s distress. Lucy has noticed that, not only do the usual clues of body language and intonation not work but, in addition, autistic adults have sometimes deliberately stopped showing distress through atypical (socially unacceptable) body language.

Both transference and counter-transference are underpinned by a supportive relationship with the client and awareness that autistic people may be less reflective or take time to become reflective, so that interventions can be made to, and understood by, the client. Lucy has found similar difficulties with transference and counter-transference to those found by Joan. Both Joan and Lucy work with the assumption that autistic people have an unconscious but that accessing it and discussing it are tricky.

Lucy had found that two issues were particularly important for autistic clients. Firstly, identity: no one can see that autistic people are different, so autistic people always face false expectations in relationships. Both society and therapy can be false mirrors in self-understanding. Some newly diagnosed clients needed to grieve the hope of being like other people. Another need was making sense of the past, including previous therapy. This raised an important issue of dealing with the aftermath of misapplied therapy, which assumed the client was neuro-typical.

Secondly, trauma: Lucy recognised the importance of being able to bring trauma to therapy. She said autistic adults had struggled through life being misunderstood; some had had distressing experiences such as not having their disability needs met at a children’s home.
The Sky Blue Ethnic Couch – Marsha

I was pleased to include Marsha in my research. Infant attachment issues are classically seen by psychoanalysis as the cause of autism (Feinstein, 2010, pp 58). Marsha is a retired attachment-based psychoanalyst, who is herself disabled and has her own particular insights. She has worked with one autistic young adult.

Curiously for an attachment psychoanalyst, Marsha’s training suggested that autism just happens. However, Marsha sees patterns in families and thinks development is also a factor. Marsha described autism as brain trauma and I wondered what she meant by this; possibly brain damage during birth (Copeland, 1976).

Marsha believes she could intuit whether or not someone is autistic through the bond between psychoanalyst and client, and through the client’s discussion of other relationships. She felt she could definitely identify autism by six months. She thinks it would be odd for a client to disclose at six months, and would wonder if people who disclosed once trust is established were blocking the work. Joan had a client who took time to overcome the stigma and mention his autism, so the assumption that the client was blocking the work may not be helpful.

Marsha would place knowledge of autism at the back of her mind during the work, rather than address autism directly, although she does think autism can be cured (to an extent). In her work, Marsha tried using art and music, much as Barbara McIntosh described in the Woman’s Hour interview, although independent of this influence. Marsha noted that transference could be frightening for an autistic client.

Marsha made a very astute observation that autistic people are not supported by society as well as people with other disabilities, such as her own visual impairment. This is due to the lack of understanding of what autism is, and the lack of support causes mental health issues for autistic people and problems for their families.
The Dove Grey Minimalist Couch – Peter

Peter, a Kleinian analyst who is influenced by critics of psychoanalysis like Laing, has a little experience of providing interventions to infants in the hope that they will have non-autistic futures. As discussed in the *Woman’s Hour* interview, diagnosis in infancy is problematic (see Appendix A). Peter now works with adults, including an autistic adult.

Peter had seen the news about the discovery of a genetic cause for autism and recognised that autism possibly runs in families, but thought that many people probably have autistic traits. Peter thinks of autism in terms of object relations; the cause being an infant not having its needs kept in mind by its carer. In his view, without intervention, this would result in permanent autism. However, Peter does not think in terms of a cure for adults, because he thinks of autism as fluctuating. Mental health conditions can fluctuate, but I would question whether autism fits such a description. Someone cannot be unable to interpret facial expression one day and capable the next, when not having a bad autism day (see Frith, 1989, pp 56).

How would Peter recognise autism? Through transference, which several of the interviewees had found not to be reliable with autistic people.

Peter shares the fears of other interviewees on labelling. He thinks that labels shut down meaning. I am surprised that identifying something and being clear about its nature – i.e. naming it – does not open up meaning, offering some understanding and control. Peter is working with someone who ‘thinks’ that they have autism. I got the impression that the client had a confirmed diagnosed from other professionals. It is difficult for autistic people to have their diagnosis disputed. As Lucy highlights, they have spend a lifetime being misunderstood. As they tend to think literally (Deudney, 2003, pp 3-4), they may also find it confusing not to be believed.
Peter’s approach shows how misguided psychoanalytic treatment of autistic clients can be. Autism is not a form of neurosis where people need to be talked out of closed thinking by fresh ideas (Feinstein, 2010, pp 187). Joan’s work with the man who would not wash looks at autism right side up. The man’s fixed beliefs about the attitude of staff at his care home were a result of his cognitive processing difference. They were a misunderstanding of reality. The beliefs were not the result of a psychological trait, i.e. a deluded view of reality. The beliefs were challenged without his diagnosis of autism being questioned.

Peter’s work is exploratory, challenging rigid beliefs about why the client is a certain way, because he thinks that concrete ideas block thinking and are based on anxieties about there being such as thing as right and wrong or certainty. As Joan discusses, autistic people can get stuck in rigid thinking. However, given the nature of autism, Peter’s approach sounds terrifying for an autistic client who, as Joan describes, will need certainty and clear boundaries.

Peter described autism as a difficulty in relating, which therapy could break down to access meaning. He does this without reference to scientific research, stating that he is not a scientist; his field is therapy. This is the kind of silo thinking which reminds me of the waiter who refused to tell me if a dish contained nuts as he wasn’t a doctor. Therapeutic technique cannot be determined upon and applied without reference to discoveries about the nature of the condition being addressed.

The Beige Sunday Morning Corduroy Couch – Stephen
In describing his theoretical outlook, Stephen referred to philosophers, including Wittgenstein’s theories on language. The autism scholar, Christopher Gillberg, believes Wittgenstein was autistic (see Appendix M). Overall, however, I am sceptical about a philosophical approach in which everything is a metaphor, as metaphor is something with which autistic people struggle (Deudney, 2003, pp 4).
Overlaid on his philosophical ideas, Stephen had other reference points on autism. He works as part of a multi-disciplinary team in the NHS, so comes across a range of views. He had heard Baron-Cohen (researcher into the impact of testosterone exposure in the womb, see Appendix M) interviewed on Radio 4’s Today programme, and was familiar with the research into diet and autism being conducted by the University of Sunderland (see Appendix K).

Stephen provided just the type of case study I thought existed and wanted to investigate; a client with undiagnosed autism in psychoanalytic psychotherapy with a psychoanalyst who had no training on autism, but awareness from general knowledge that psychoanalysis and science offered different views on autism.

After a couple of years of working with a client, Stephen raised the possibility with that client that they had autism. Stephen now wonders whether former clients might also be autistic. The client he identified responded by finding out about the condition and thought it fitted.

Stephen sees autism as a description, not a diagnosis. This would fit Stephen’s professional background; he cannot diagnose autism and fits his view that autism is a metaphor for how the client operates in the world. I wonder if philosophical Stephen would view cancer as a metaphor. Autistic people are, by definition, literal (Deudney, 2003, pp 3-4) and I fear that coping with professionals who hold the idea that autism is a metaphor will be problematic for the client, as autistic people tend not to think metaphorically: think of Haddon’s Christopher Boone who thinks that metaphor is lying (Haddon, 2004, pp 56). Talking about autism as a metaphor to someone who does not relate to metaphor could be confusing and, therefore, disempower the client.

Stephen recognised autism when his client repeated unhelpful patterns of social behaviour. He talked through his options, but when similar situations arose, repeated
his unhelpful behaviour. This is just what Joan observed; autistic clients see how they need to change, but cannot do it, and so need a different type of therapy. Stephen’s approach was to ask for new reflections to stop the client repeating old observations – the implication was that these reflections lead to the client changing his behaviour. Stephen found some techniques did not work for autistic clients; lateral thinking and free association were not possible. Problems with transference have already been noted and here are other psychoanalytic tools proving problematic. How then can an autistic person’s unconscious be reached?

Stephen’s autistic client knew about psychoanalysis, but had not found these ideas useful. Stephen reported that the client’s literal response to psychoanalytic ideas had turned his life into a fixed story, which I think meant that there was no room for insight to lead to growth or new insight to be made.

Stephen aims to help clients feel comfortable being themselves in the world and, with autistic clients, adds to this the aim of being more comfortable socially; which I think recognises the particular issues autistic people face and bring to therapy.

If autism was disclosed at the start of therapy, Stephen would ask if it was something the client wanted to talk about. I assume he means in contrast to something the client thought the therapist should know. This struck me as a particularly sensitive approach. Stephen also had a striking response to what he would do if disclosure of autism was made by a client at the six-month stage. He would look at the implications for the therapy – whether the client needed him to use a different approach and whether the client needed signposting to support outside therapy. What a helpful response!

Stephen has done some self-reflection on his own autistic traits. As he described this, I felt he was talking about the humility to question his assumptions about himself and try to draw on his own experience to identify with the client as much as this is...
possible. However, beyond the problem all therapists have of not knowing what it feels like to be someone else, a neuro-typical therapist has not experienced what autistic people have experienced, which Joan describes as ‘a different sort of other’.

Stephen’s fear of pinning anything down means he is most open to learning from case studies. I wonder if Stephen is missing important information from the scientific community. Research is being conducted in many fields and there is no process available for psychotherapists to keep up-to-date on autism, other than the general media, which does not focus on therapeutic work.

The Peach Avant-Garde Artist’s Couch – Titania

Titania’s training touched on autism; on her course there was a guest speaker, Marie-Christine Laznik, who talked about her interventions with infants, which aimed to prevent autism developing. Titania had also brushed with autism in her practice, as one of her clients has an autistic brother; a young adult.

Titania’s brief experience of autism makes her wonder if psychoanalysis is appropriate for autistic adults. She understood that autistic people had emotional needs, but wished to tread carefully; finding out what the client’s expectations were of dealing with another person in therapy. I found this both a daring observation about psychoanalysis’ limitations and a very practical approach to ensuring that analyst and client shared expectations.

Titania was uncertain about the cause of autism, but concluded that there was more scope for people with less apparent autism to benefit from psychoanalysis. Titania recognised that, whatever autism is, the psychological impact of autism was something that could be addressed in psychoanalysis.

In response to the question on whether autism was developmental, Titania said she would ask a client about their developmental history, which surprised me as few
people can comment on their care in infancy. I suppose Titania had in mind later milestones, but asking the client still relies on the autistic person having insight into their experience and the behaviour of those around them. Autistic people find the actions of others hard to understand and also have trouble reflecting on their own experience. Think of the hero of the novel *The Curious Incident of the Dog in the Night-Time* (Haddon, 2004, pp 191), who is oblivious to much of his parents’ marital conflict, which is all too apparent to the reader.

Perhaps Titania’s approach was informed by working with a family member of someone with autism. This draws attention to the challenge of supporting an autistic relative and is the other part of the picture to helping an autistic person through involving their families in the therapy; an approach that Brian, Joan and Lucy use.

Like Colin, Titania notes that she could miss autism as it is not something psychoanalysts look for. Like Douglas, Titania would signpost clients to their GP should autism come out in the psychoanalysis. Knowing how to spot and respond to autism is a skill psychoanalysts are not trained to do. However, Titania was aware that autism is something clients are wondering about if, as she put it, they are obsessive, hard working or romantically unlucky. Titania is not sure diagnosis is always useful to clients. I wondered how it could ever not be useful to have the self-understanding that comes from knowing the truth. Gunilla Gerland is not unusual in feeling relief on being diagnosed; finally able to make sense of her life (Gerland, 1997, pp 280). I wonder if other diagnoses would be thought of as unhelpful, for example, M.E. (Myalgic Encephalopathy).

**Can Psychoanalysis and Autism Be Friends?**
Several vital issues about psychoanalysis’ response to autism were raised by the interviews. Focusing on the issue which was a stumbling block for so many; can psychoanalysis and autism ever be friends or will transference (counter-transference) always get in the way?
Autistic people’s experience can be compared to visiting a hall of mirrors at a fun fair. Each mirror they look into reflects back a distorted image. In society, they are accused of being evasive or rude when this was not their intention. In psychoanalysis, interpretations are made based on false assumptions. The experiences the client expresses are unusual and what the analyst understands can be wrong. Self-awareness and communication skills are missing in the client, so the false assumptions of the analyst may not be challenged and the work ends up compounding the client’s poor self-understanding with misinterpretations.

In his letter from a Birmingham jail, written on 16 April 1963, Martin Luther King Jr summed up the effects on minority groups of looking into such mirrors and internalising the distortions, ‘... when you suddenly find your tongue twisted and your speech stammering as you seek to explain to your six-year-old daughter why she can’t go to the public amusement park that has just been advertised on television, and see tears welling up in her eyes when she is told that Funtown is closed to colored children, and see ominous clouds of inferiority beginning to form in her little mental sky, and see her beginning to distort her personality by developing an unconscious bitterness toward white people ... when you are harried by day and haunted by night by the fact that you are a Negro, living constantly at tiptoe stance, never quite knowing what to expect next, and are plagued with inner fears and outer resentments; when you are forever fighting a degenerating sense of "nobodiness" then you will understand ...

This is exactly what autistic people have experienced; distorted reflections which leave the autistic person with a diminished sense of self. They have been sawn in two, often by those trying to help such as psychoanalysts who misread the client’s communication.

I started my research looking at how psychoanalysts understood and responded to autism. I discovered a wide-spread lack of training and clarity on the nature of
autism, and in some cases, the application of inappropriate techniques. I conclude that more training is needed to prevent autistic clients being unrecognised and treated inappropriately.

To tackle their emotional issues, autistic people need therapy that offers a true reflection of themselves. The therapist has to mirror a ‘different type of other’ – as Joan put it. Some of the interviewees were attempting to do this, and I hope you have been inspired by them.

As the psychotherapeutic profession in general learns to see autistic people as they really are, emotional healing will be more likely for autistic people. As autistic people have complex emotional needs, I hope that therapies which look in depth at emotions will play a role in this work; particularly, of course; psychoanalysis.

‘And we all, with unveiled faces reflecting the glory of the Lord, are being transformed into the same image from one degree of glory to another’.

2 Corinthians 3 v 18

Finis
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