

## **DYADIC REPAIR: A CLINICAL APPROACH TO AUTISTIC RECOVERY AND PRODIGY RETRIEVAL**

**Rima Laibow, M.D.**

### **ABSTRACT**

Clinical evidence with the group of autistic and autistic-like children treated through Dyadic Repair in this country and in Europe suggests strongly that many, perhaps most, autistic persons are prodigies. It appears that autists are persons gifted with prodigiously high intellectual and empathetic endowments who, early in their developmental lives, learn to use an overwhelming, pervasive withdrawal and rejection of the environment. Because of a combination of intrinsic and extrinsic factors (coincidence), these children remain in a position of extreme withdrawal and retreat with deficits which potentiate (and are potentiated by) pervasive and sadistic rage in the face of failed attachment. Appearing unreachable and out of contact with the environment they are, in fact, intensely connected to it. Regardless of the pervasive and discouraging appearance of the neurological, metabolic and physical damage which may be present, the apparently untreatable state of the autist must not be taken as conclusive proof of the unassailable nature of these disabilities. Rather, they may be potentially remediable deficits.

**KEYWORDS:** Dyadic repair, autism, prodigies

## INTRODUCTION

**A**utism is a devastating disease. It devastates the autistic person whose entire life consists of tragically limited frontiers and custodial issues, little aided by conventional therapeutic intervention. It devastates the family of the autistic person whose hopes, love, resources, and family integration, are violently distorted. It devastates the fiscal resources of care-taking systems since life-long institutional care is terribly expensive. It devastates us as a society because of the loss of potential contributions of healthy citizens to our financial and social well-being. And most unremarked of all, it devastates us as a species because considerable evidence suggests that our autistics are, in truth, the majority of our child prodigies, our exceptionally gifted individuals. This paper discusses the relevant issues concerning the autism-prodigy connection, presents discussion and evaluation of previous treatment modalities and, finally, proposes a course of treatment designated Dyadic Repair. Three case histories, including outcomes, illustrate the therapy.

A child prodigy exceeds expected developmental norms by substantial (and sometimes surprising) margins in one or more important areas. The prodigiously able youngster shows capacities and areas of mastery customarily attained only by talented individuals many years older than the child or, sometimes, not attained by any but the most exceptional adults. Making the study of prodigious children yet more complex, Halbert Robinson, who documented the growth and development of a group of exceptionally gifted children (including child prodigies), observed that these special and uniquely capable youngsters differ even more from one another than they do from the general population.<sup>1</sup>

A child prodigy may be focused on a single domain of excellence (e.g., the superb chess player, the kinesthetically endowed gymnast or dancer, the math whiz, the sculptor, the cellist), but more confusingly, the child may be one whose unique endowment is not in an area easily seen through output. Instead, his or her gift may be in a moral, ethical or conceptual area. Rare but important examples of such talent range from reports of Jesus teaching philosophy and ethics at the gates of the Temple as a pre-adolescent to the well-documented case of Maimonides, who, while still a small child, gave formal instruction in Torah to learned adults. Further, prodigious children may defy simple categorization by remaining multi-potential. David Feldman and Lynn Goldstein coined the term "Omnibus Prodigy" to describe the remarkable Adam Konantovich in "Nature's Gambit", their study of six prodigious boys and their families<sup>2</sup>.

The single unifying characteristic which defines a child prodigy, however, is that the child clearly demonstrates her (or his) ability to perform, or conceptualize, in one or more fields of endeavor, at a level substantially exceeding age-expected mastery by other children (or, indeed, of adults) in the area(s) of the child's specialization (often by ten years or more). In other words, membership in the classification depends, according to current thinking, on a clear and easily seen demonstration of capacities and behaviors which mark the child as exceptionally *enabled*.

This enablement demonstrates itself in an unusually active and receptive response in the area(s) of the child's prodigious gift(s) as well as a demonstrated output level of unusually high quality as adjudged by both professional and lay observers.

It may therefore seem surprising and paradoxical to suggest, as I do, that by far the largest sector of the child prodigy population resides within a large and severely *disabled* autistic population. These children are disabled *specifically* in their capacity to respond appropriately to the world.

**W**hat I am proposing may seem a peculiar assertion to psychotherapists or to other clinicians or experimentalists without direct experience in autism. Autists appear to be among the least responsive, least learning enabled and most defective children known. Except for rare and unproductive instances in which they show areas of spared functioning (e.g., lightning calculators and other savant-like behaviors such as the widely known case of the artist Nadia, documented by her therapist<sup>3-6</sup>) they would seem to be the most un-prodigious children possible. And yet, if autists are indeed child prodigies, then a stark and terrible fact emerges: unless they can be retrieved, most of the child prodigies in our culture are doomed to spend their lives as isolated, non-verbal, apparently profoundly retarded citizens requiring life-long custodial care. Left as they are, almost without exception they do not have the least hope of forming lasting attachments or making any contribution whatsoever to society. That is the general fate of the autist<sup>7</sup>.

## **BACKGROUND**

Autism was first identified as a discrete syndrome by Leo Kanner in 1943<sup>8</sup>. In his initial report he defined a group of children who exhibited failure of attachment: they were isolated and unattached, did not make eye contact, displayed marked speech abnormalities and failed to learn and grow intellectually. They engaged in self-

stimulating behaviors but did not respond productively to external stimuli. They were, he said, generally the children of cold and unavailable parents, likely to have mothers to whom Kanner eloquently but (to professionals and mothers alike) alarmingly referred as “refrigerator mothers”. The resulting isolation of the child represented, he felt, a turning inward toward the self or auto-focus, hence the term “autism”. Kanner’s article produced a storm of affirmation and attack which resulted in supposedly scientific “sides” being formed. The stimulating and very threatening idea that a *mother*, any mother, could be that “bad” injected a level of passion and fervor into the debate which is, fortunately, uncommon in scientific discourse.

**F**or nearly 50 years, proponents of one camp or another have hotly supported (and equally hotly contested) the “emotional” (dynamic) etiology proposed by Kanner (and practitioners like Bruno Bettelheim<sup>9</sup>) and the “organic” or biological bases proposed by such workers as Bernard Rimland<sup>10</sup>, Barbara Fish<sup>11</sup> and Edward Ritvo<sup>12</sup>, as if these various etiologies could possibly be mutually exclusive. Autism has been variously conceived as a state of deprivation, an inborn error of metabolism, a nutritional deficiency, a subclass of retardation and a type of intractable childhood psychosis.

Recent information suggests an oversupply of a class of neurochemical compounds which reduce the child’s incentive to search the environment for gratification in a normal manner. But treatment regimens ranging from the psychodynamic through the behavioral to the chemical have produced uniformly poor results.<sup>13</sup> Following Kanner’s observation that these children generally were the offspring of cold, poorly-related mothers, psychodynamic causes were postulated by a number of workers. Best known of these was Bruno Bettelheim, whose notion of the “Empty Fortress”<sup>9,14</sup> provided a picture of the defended or depressed child who, failed by his mother, could be “cured” by his therapist instead. Bettelheim and his followers attempted to “fill” what mother had left “empty” and achieved some success. But the successes were partial and relatively unsatisfying. In addition, there were so many variables in this therapeutic system that replication and evaluation were difficult.

O. Ivor Lovaas<sup>15</sup> and others focused on the deficient response of the child to the environment. Reasoning that the child related poorly to the environment and building on the behaviorist notions then in vogue, behavior modification programs were created in order to modify the capacity of the child to relate to the world. These programs ranged from the benign to the cruel, from the supportive to the abusive.

They were intended to force, seduce, compel, entice or reason the child away from what was perceived as a profound and sterile isolation. A child who, for whatever reason, was perceived as being unable to entrust himself fully and well to the environment found himself being subjected to those stimuli which he found most aversive. When he behaved in such a way that his behavior suited himself best and the environment least, he was routinely denied access to various comforts and necessities since he failed to meet the expectations of his caretakers. In such a case he would be subjected to a regimentation which matched his own rigidity: the difference, of course, was that *his* rigidity was deemed to be unacceptable by those in a position to make such decisions and they enforced consequences to his unacceptable behaviors. The approach stemmed from the basic notion that the withdrawn child's state must be made so unpleasant that the isolation will be less desirable, ultimately, than coming out into the very world peopled by those who are currently abusing him by application of noxious stimuli or deprivation.

Some workers, like Frederick Stone, were aware that the autistic child probably lived in "chaos ... especially the chaotic attempt to understand the spoken language. It is not surprising that the child seeks to create for himself ... 'perceptual monotony'. When the impressions coming in from the outside world produce turbulence, it is not surprising that the child tries to regulate sensory input by, for example, perseverative and ritualistic behavior. These are not rituals to be analyzed and interpreted. They are the child's desperate coping with terror."<sup>16</sup>

**L**ooking for biological concomitants, Rimland<sup>18</sup>, Rutter<sup>19</sup> and others sought inborn or environmentally induced errors of metabolism. Etiologies based in trace minerals, environmental pollutants, megavitamin deficiencies, neurological imbalances, neurotransmitter deficits, enzymatic aberrations, and dozens more each gained supporters. Each garnered favorable early notice and then became yet another pathway to follow in the confusing and disappointing morass of partial fulfillment in the search for cause, and treatment and cure of this devastating disease.

With the exception of the early attachment theorists, each school and system of belief (however different their outward focus), supposed that there was one (or a small number of) basic deficit(s) so deeply engrained in the biology or neurology of the autistic that there was a very serious upper limit to any possible repair. Correction of neurological or physiological or enzymatic or metabolic errors is not fundamentally possible, they reasoned. Certainly emotional components could be comfortably

ruled out as factors of either causality or cure. And in the face of the rather dismal record of success of the attachment theorists and other dynamically focused workers, ruling out such factors as causative appeared to be justified. But suppose the dynamically focused workers like Bettelheim were basically correct, yet naive?

**S**uppose that, rather than ascribing autism to a failure of attachment, they simply lacked the tools to implement their insight and the theory to articulate their understanding? Suppose they had not been wrong when they noted the connection between despair, abandonment and autism? Suppose that the most retarded, regressed, psychotic, ritualized, isolated, withdrawn and neurologically damaged child were truly autistic *and* able to cease, under the right conditions, being autistic? Suppose that these damaged children were capable, under correct (and corrective) circumstances, of compensating for the neurological damage sustained (and potentiated) by their currently observable state? Suppose that repair of basic deficits was possible by invoking a later-life analogue of that unique fetal plasticity which normally allows the development of correctly oriented and structured embryological organs and tissues during early development?

Fetal plasticity allows differentiation from basic tissue as well as early repair if circumstances are right. If it could be reinvented, might not basic metabolic and structural repair be accomplished? Or, perhaps, basic damage might be compensated for, allowing functional, rather than organic, repair. Suppose, too, that there were some way of “resetting” the neurochemical ratio of receptor sites for stress-related neurotransmitters (e.g., catecholamines) and non-stress or pleasure neurotransmitters (e.g., the endorphin group), laid down in the brain around the time of birth?<sup>219-22</sup> The implication for autism would, of course, be enormous. It would then behoove parent and therapist to look with great vigor for ways to trigger this early plasticity or capacity for compensation in order to retrieve the autist from his or her isolation.

## **TREATMENT MODALITIES**

Whatever autism’s etiology(ies), the intense polarization of thought, and the ferocity of the resulting debate, makes it clear that deeply cherished beliefs and feelings are stimulated by the consideration and treatment of these children. In fact, it is possible that at least some of the more extreme modalities of treatment, as well as the vehemence with which these debates are pursued, represent unrecognized but dam-

aging acting-out by researchers and therapists in order to discharge intolerable and unknown feelings and impulses roused by these children. Few other disabilities have been responded to by therapists finding the most unpleasant thing in the world of the child, and then applying it to the child whenever a symptom reveals itself, and labeling such treatment "therapeutic intervention". Few other disabilities have resulted in children being pinioned by six or seven powerful bullying adults and goaded to rage and despair. And few other disabilities have resulted in the canonization of a myth which holds that if anyone gets better it proves conclusively that they were not really afflicted with the disorder in the first place. These strange and unusual beliefs and behaviors should be examined in light of their content and context and not merely accepted because they bear the sanction, as the Humors did for two thousand years, of time and authority.

So deeply held are the belief systems about this puzzling malady that salient information running counter to them has been repeatedly overlooked or denied by most workers in the field. For example, it has been known for some time that in non-Western cultures, autism, either in frank or in partial forms of expression, is virtually nonexistent. With the coming of Western patterns of living and working and the breakdown of traditional child rearing and family systems, however autism rises steadily and inexorably. With full Westernization, it reaches the same levels as in other Western cultures. In the United States and in Western Europe, frank autism is found in about nine children out of 20,000<sup>23</sup>. Also, partial expression of autistic characteristics (so-called "autistic-like" children and improperly diagnosed "retarded" children) account for many times that number<sup>13</sup>. For example, Fish and Ritvo estimate that another 2 per 10,000 children were psychotic, but did not meet the full criteria for autism<sup>23</sup>. Retardation on a functional basis (currently indistinguishable from neurologically vulnerable children who approach, but do not quite manage, the grand withdrawal of the autistic) will, of course, add many more withdrawn and non-functional individuals to each moiety of 10,000.

**T**he number of autistic males is said to be from 2 to 6 times greater than the number of females with autism.<sup>23</sup> Further, most studies find a relationship between upper social class family background and a tendency toward autism.<sup>23,13</sup> Additionally intriguing, the parents of autistic youngsters divorce significantly less often than other people, suggesting that there is a binding effect on the relationship between them exerted by the autistic child<sup>24</sup>. The implications of these intriguing facts, suggestive of at least some possible environmental factors of causality, have also been largely ignored.

We do not know with certainty what vulnerability factors are inherent in being male, from an upper socioeconomic class, and highly gifted. But it would appear that a vulnerable population, protected in a pre-technological culture by social and familial factors other than those operative in Western technological culture, succumbs to the risk matrix to which it is exposed in the course of Westernization. Yet this striking and disturbing factor is not accounted for, or attended to, by the reigning paradigms in the West, any more than they are by the demonic possession theory of autism.

**T**he developmental and medical professions have not been helpful or productive in this regard. In their favored dualistic models they reinforce the most mechanistic and behavioristic interpretations and conceptions of autism. Worse, they rupture further the weakened bond between parent and autistic child. Through institutionalization and treatment modalities which *intentionally* exclude the “toxic parent”, substituting staff and therapist, repair and reattachment of parent and child becomes less and less possible. Further, they often choose to use aversive and/or chemically numbing treatments against behaviors as if these behaviors were, *in themselves*, the disability, rather than its product. Diagnostic schema have multiplied as the imprecision of the syndrome lead to the search for better definition of the attendant deficits.<sup>13</sup> Psychoactive, antipsychotic, stimulant, depressant, antidepressant, anticonvulsant (and a host of other) pharmacologic agents have been employed in the attempt to control behavior and increase the functional level of autists.

While acknowledging the many strands which contribute to the picture, George Victor, after studying all available literature, concluded that autism is, first and foremost, a disease of disordered maternal-infant attachment.<sup>13</sup> He cited the counterintuitive, but highly significant, fact that mothers of autistic children, while sincerely interested in having their children well or, as they may perceive it, well again, nonetheless harbor dearly held *unconscious* fantasies about their autistic children. These fantasies, usually held entirely at the unconscious level, represented the autistic child as very special to their mothers, to God and to the world.

These children were, in the meaning that their mothers ascribed to them, special gifts. Some mothers believed that their special children were messianic and God-like in their inner, remote selves. In many cases they represented a divine statement, or were autistic in order to give purpose to their mother’s life. In other words, each of these mothers harbored an intense, unconscious, deeply held and, to her, precious reason (or reasons) that it was not only acceptable, but actually preferable for her



child to be autistic. At the unconscious level she chose, she preferred, the child as remote, as unavailable, as disordered as he was. And yet, her conscious wishes were very different indeed. Because these mothers were also motivated by *conscious* wishes, they often exerted extraordinary efforts to find treatment for their youngsters, to get help, to reach out for hope, completely unaware of this powerful inner fantasy life they had created around themselves and their children.

## RELATED SYNDROMES

The existence of deep resistance to repair, and simultaneous ascription of deep unconscious significance to the disease itself, is not limited to autism, or to behaviorally based diseases. Similar unconscious mechanisms in other serious illnesses have been identified. For example, Dr. Arno Gruen, a Swiss psychoanalyst, studied the families of 20 children who had died of birth defects or other identifiable causes and 20 children who had died of Sudden Infant Death Syndrome (SIDS).<sup>25</sup> He did not know, of course, what the cause of death of the infants was when he conducted the interviews. It soon became apparent, however, that there were marked differences between families who lost a baby to SIDS and those who lost a baby to a congenital birth defect or other physical cause.

**O**f the 20 families who had lost children to birth defects and other physical causes, Dr. Gruen was able to identify none in which there was an unconscious wish for the child's death. Instead, he was able to identify a range of grieving processes from the normal to the pathological. In the SIDS families, however, the picture was very different. In 19 of these families there was clear indication that the mother, and in some cases the father as well, had harbored a strong unconscious wish for the death of that child. At interview, Dr. Gruen was able to identify some aspect of gratification or satisfaction of the wish for the child's death in each of these families even though such gratification was out of conscious awareness. In the 20th family, which stood out in stark contrast to the other SIDS families, the parents were mourning the loss of their baby without any indication of a wish for its death. Subsequent autopsy results on that baby revealed that the diagnosis of SIDS was an error. The child had a previously undetected congenital birth defect which, until autopsy, had escaped detection.

It is important to note that the families interviewed were selected solely because of the death of their children, not because any psychopathology had been noted or diagnosed. Many families in both categories had successfully reared other children. The SIDS parents made a clear, but unconscious, differentiation between the surviving children and their roles in the unconscious lives of the parents and that of the deceased child. In SIDS families with more than one child, this distinction was conspicuous and consistent. The SIDS child was not wished to live. The parents were unaware of this fact in their lives and hearts and would, most surely, have had extreme difficulty with such a notion had it been introduced clumsily, intrusively or prematurely.

**S**everal of the SIDS families had lost a number of children to SIDS. Although psychological exploration or working-through had not been carried out, if their fantasies had been worked through it is reasonable to expect that this deadly contribution to the loss of their children might have been reduced or eliminated. It is reasonable to think that the working through of such fantasies and needs by the parent might allow for an unfolding of the child's abilities to grow more normally, indeed, even to survive. Parental fantasies which potentiate the retreat, and intellectual, emotional and experiential deficits on the part of the child usually are ego dystonic to the parent, and may be carefully defended against being uncovered. But, once available for working through, in many cases normal parental attachment allows considerable gain to be made in relatively short order.

In autism, it is the functional and developmental status of the child rather than his body which seems dead. The potentiation, joy and depth which a growing child can bring to his family seems to have died or to have been "taken over" by someone else. The disease requires the unfortunate coalescence of several vulnerabilities at one time in a particular matrix of ability and disability. This vulnerability is negatively potentiated by the covert, unconscious intention of the mother (and, usually, father) to maintain the child in a retreated position. This unconscious intentionality, it must be noted, must not be converted into blame by either therapist or parent. The unconscious wish and fantasy life of the parent is in sharp contrast to the conscious action-life of the same parent who, typically, invests tremendous time, energy, love, sorrow, anger, grief and money in a series of attempts to retrieve and to love this child. Parent and child repeatedly fail each other, however. Neither knows why this happens nor can tolerate the failure on the part of the other. Mutual retreat follows mutual disappointment which follows on mutual retreat, and the cycle spirals downward.

## DO-IT-YOURSELF REMEDIES

Significantly, as a continuing counterpoint to professional reports of strikingly limited success with autism, occasional reports from the lay public have been published in which parents have conducted what Nobel Prize winner Nikko Tinbergen calls "Do-it-Yourself Rescues."<sup>26</sup> These families and occasionally, the child's therapist, report on their success in the partial or total cure of particular autistic children through almost unbelievably intense and sustained efforts. It is these efforts which ultimately compel (or allow) the child to connect affectively with them. This *connection* is the vehicle for repair, and is the point of this paper.

Popular books and films tell these important, moving and powerful stories.<sup>27-29</sup> These are the sagas of autistic children in whose families the strength of the fantasies we have been focusing on was not as great as the countervailing wish by the parents that the child cease being autistic. The response of the professional community is almost unanimous: *the recovered child's diagnosis of autism is retrospectively revised*; since he really recovered, then obviously he was not really autistic. It is important to note that the diagnosis of autism thus includes a strong defeatist overtone.<sup>5</sup>

**S**ince autism is defined as incurable, the notion that it might be expected to remit under any regimen whatsoever is, according to most mainstream thought, something of an oxymoron, and the idea that there is anyone "inside," so to speak, who can be retrieved from that retreated position is unpopular. Apparently easily countered by the specter of misdiagnosis, it is rather like the dunking of accused witches during the middle ages. If the suspected witch survived the dunking, then she was fit to burn since she had proven herself a witch. If she drowned, she was exonerated (but dead). All of the diagnosticians, neurologists, developmentalists and physicians who concurred that the child was autistic have been proven wrong by the later development of normality by the child. They must all have made a serious, but joint, error of judgement.

A parallel example of retrospective magical thinking within the scientific community is reported by Benjamin Brown in *The New Legend*.<sup>30</sup> Brown recounts the case of a Stage 3-4 *glioblastoma* diagnosed by a world famous neurosurgeon and a similarly qualified neuropathologist. This aggressive and deadly tumor "always" has

a terminal outcome. Following intensive meditation and visualization, the tumor regressed and the symptoms which were connected with its presence ameliorated significantly. Since such improvement is totally inconsistent with this type of tumor, it was retrospectively rediagnosed on the basis of the lack of conformity with expected terminal outcome, not on the basis of clinical or microscopic findings which still clearly present as Stage 3-4 *glioblastoma*.

**E**ven though some children are retrieved from what must be reasonably acknowledge to be autism, such “do-it-yourself” retrievals are often far from complete. A few of these retrieved children may function in some areas as exceptionally capable people, but most of them are still severely abnormal or limited in one or more aspects of their lives. One thing is consistently true among these persons, however; their memories of events and feelings, sights, sounds, smells, losses and separations, of very early occurrences, are clear and accurate. It is important to note that these events occurred while the child appeared to be totally unresponsive, withdrawn, unreachable, completely unable to learn or retain material. In short, these memory traces were laid down while the child was believed to be turned so completely inward as to warrant the label “autistic,” and so incapable of normal intellectual functioning as to deserve the label “retarded”.

Yet, in spite of all evidence to the contrary that these children could be retrieved, they *were*. These courageous “do it yourself” retrievers allowed us to learn from the children themselves that an intensely active intellect lay buried in that unresponsive and profoundly defective child. When they choose to speak, there is no shortage of accurate recounts by these children of the speech, precisely decoded, of those around the child in early, unresponsive years. No subtlety of the environment was lost on this child; the nuances of feeling and behavior affects him deeply (and painfully). These were thinking, feeling, hurting children so deeply wounded and so painfully distrustful that they literally make the only (to them) life preserving choice they can; to retreat so deeply that, to the eyes of parents and professionals alike, they appeared to be absent.

The consistent availability of accurate and well organized memory traces is a piece of the puzzle of autism customarily overlooked. So is the data generated by Nikko Tinbergen when he carried out ethological microanalysis of autistic children’s behaviors. Following his receipt of the Nobel Prize in 1977, Tinbergen, in his Nobel address, proposed turning the tools of ethology to autistic children and, indeed, did

so for the remaining years of his life. His work was remarkably productive. Tinbergen showed dramatically and conclusively that the apparent isolation and withdrawal of the autistic child, even the most frankly neurologically damaged autistic child, was just that, *apparent*.

He demonstrated elegantly and repeatably that the seemingly aimless wandering of autistic children, like the seemingly aimless wandering of the stickleback fish<sup>31</sup> was, in reality, a complex dance of approach and avoidance through both space and time. He was able to chart the child's dance with precision and show that it described a semicircle of approach and avoidance around the body of the child's mother.<sup>26</sup> Tinbergen showed that if mother were seated in a chair at one location in a room, over time the seemingly patternless circling of her child described an arc of constant radius from her. When he repositioned her elsewhere in the room, the child's apparently aimless excursions would take on another otherwise unnoticed orientation, and within minutes would describe the same perimeter of approach and avoidance around her new position. This dance could only be seen, however, through careful microanalysis of the totality of the child's movement. Observation of his apparent behavior, so to speak, without reference to his behavior through time *and* space, yielded incomplete and incorrect information about his intention and, therefore, about his capacity. and the meaning of the behavior.

**A**utistic children are noted for, and, in some measure, defined by, their failure to make eye contact. Yet when Tinbergen studied eye movement, it was consistently seen that autistic children were, in fact, masters of eye contact.<sup>26</sup> The autistic child was seen to dance with his eyes like a classical Indian dancer of consummate skill. Glances toward and away from mother were choreographed with such exquisite mastery and precision that each time *she* blinked or averted her gaze, *he* glanced or gazed at her eyes. Each time she glanced or gazed at him, he had already shifted his eyes from her. Thus, they danced together, always in synchrony, always out of harmony. Each perceived the other as unavailable, as avoidant, as abundantly disappointing and unfulfilling.

It is difficult to avoid the conclusion that mother and child must be locked very deeply into this reciprocal system and, in fact, Tinbergen's work with frank autists and their mothers confirms this conclusion. At the unconscious level, even the most apparently regressed and limited autistic child, although laden with documented and irrefutable neurological burdens and deficits, seems to be capable of an intense

engagement consisting of nonengagement and avoidance. His mother, too, is locked in a confirmatory and synchronous dance of mutually reinforcing avoidance.

**T**hus, the mother simultaneously and unconsciously maintains the retreated position of the child and consciously attempts to find some way to woo, or medicate, or coerce the child into her world. The ways in which the child seeks the world, and the world attends to him, fail, again and again, to make it possible to convey to him that such an option even exists. The world and he fail, over and over, to create the circumstances, neurochemical, behavioral, affective and conceptual, which will give him access, finally, to the experiential richness that most of us know. He lacks nothing in perceptual richness but he is locked into a prison largely of his own making which prevents his experiencing the world fully through healthy interaction with it.

So the autistic strives to accomplish two mutually contradictory goals. On the one hand he seeks to compel the world to attend to him in some way that meets his needs. On the other hand, sometimes in the same behaviors, he seeks to baffle all attempts at reaching him. He actively seeks to remain in his retreated position as long and as deeply as he can. It is as if he has constructed a developmental game. It is not the developmentally appropriate game of "Peek-a-boo" in which the appearance and disappearance of the mother is laden with anxiety, but released in pleasure, rather, it is a far more disruptive and damaging game of "Come Catch Me." The rules of "Come Catch Me" are simple and deadly:

*I know because I am symbiotically fused to you that you know what I feel, who I am, what will comfort me. (Of course, I am wrong, but that possibility has never occurred to me.) Since you know what will comfort and please me and you have still allowed me to be in pain or unhappy, that proves that you do not really love me. But my survival requires that you love me. To find out if that is truly the case, I will hide from you and tell you what I need and want only in stereotyped and coded ways. If you decode my message successfully, we can be a couple and I can grow. If not, since I know you understand my code, I will vent my rage on you (or myself) for not making me happy, loving me, comforting me. However, in order for me to know that you really want to comfort me, I will make the task as difficult as possible. If you come near me, Mommy, I will fight you in every way that I have*

*to make certain that, if you win through, you really wanted to. I will make my codes as obscure as I can for the same reason: If you succeed, then perhaps I will be assured that you really did understand me: my system will be validated and confirmed. Come catch me, Mommy, but, to make sure that you really want to, if you come anywhere near me I will scratch your eyes out.*

**T**his psychotic and symbiotic way of thinking is, to say the least, counterproductive, and yet, when retrieved, this is what autistic children report that they have been thinking and putting into motion. Mother is seen as the symbiotically all-powerful, and all-fearful creature who must be defeated, wooed and defended against. All this, in a very young child, requires a powerful intellect, the capacity for high-level processing, planning, reasoning, and an exceptional personal strength of will. It is likely that even this level of prodigious ability alone would be insufficient to account for the development of autism. It is likely that a genetic predisposition towards a heightened stimulus barrier (and perhaps other genetic components as well) must be present for the development of frank autism. Partial expression of the disorder would, of course, depend on the mix of capacities, disappointments and parental input in each child's life.

## **THEORY OF DYADIC REPAIR**

Since we know that a failure in bonding and attachment between mother and child results in losses and deficits for any mother-child dyad,<sup>32-36</sup> it seems reasonable to conclude that whatever the complex mixture of etiological factors, *both* mother and child would benefit by treating profoundly withdrawn, apparently psychotic, retarded (sometimes, as far as science can ascertain, deaf and blind) children *with* their mothers, in a therapy designed to forge and/or repair their basic deficit in bonding. Surprising and impressive information has become available. The therapeutic method which I have used to accomplish this task I call, Dyadic Repair, related to, but somewhat different than, the modality formerly known as "Holding Therapy".<sup>37</sup>

It is my contention that in order to be frankly autistic, children must be particularly enabled and skilled (or genetically endowed) in the capacity to remain unresponsive, and they must be particularly and profoundly angry. In short, they must be both prodigious and profoundly enraged. Such skills may co-exist in autistic children even

in the face of overwhelming evidence for neurological damage which, according to our current medical paradigm, is totally incompatible with the level of ability, indeed, of genius, of which we are speaking. Clinical evidence suggests that repair of such deficits, or compensation for them, is indeed possible once the dynamic, affective, functional conditions necessary to trigger such alteration are manifested on a sustained basis.

**W**orking on the assumption that high intelligence is at least potentially available in the autistic, Dyadic Repair predicates that a connection must be made between mother and child, and that this is accomplished during a physical, as well as a psychological, demand by mother for intimate and sustained contact, *which the child is able to understand*. This contact may be fought off with considerable vigor for a prolonged period of time. In the course of this battle mother may be forced to exert extreme physical effort simply to accomplish the important first, but most mechanical, goal of this therapy; to hold *and be held* via physical and visual contact. Once such mutual holding is established, the rest of the work can take place. Mother and child work together to repair the essential dyadic attachment.

It should be noted that I did not embark on Dyadic Repair of children and their mothers in order to liberate the child's prodigious intellect. Although I already had an active personal and professional interest in prodigies, I made no connection between autistic and prodigious youngsters. Like my peers, I did not suspect the existence of prodigious abilities in the autistic population. Autists were treated with Dyadic Repair because that seemed to be the only pathway which offered any possibility at all of a productive life for them. Their families, especially their mothers, usually had experienced numerous treatment failures under other regimens. But they were willing to undergo what amounted, in many cases, to a "last ditch" effort before they allowed their children to be placed in institutions. (Indeed, upwards of 87% of all autistic children in this country are ultimately permanently institutionalized.)<sup>38</sup> Committing themselves to a rigorous and difficult therapeutic regimen, these mothers undertook to overcome their own reluctance and the profound withdrawal of their children to retrieve them. They made the necessary effort in order to repair or forge an attachment which had, for a variety of reasons, gone awry in the early life of this child.

Startlingly, in *every* case I have seen in which retrieval of the autistic child is advanced enough to allow the child's actual intellectual and cognitive levels to be



assessed, the child has shown truly prodigious ability during and following retrieval. In *none* of these cases has regression or loss of skills occurred subsequent to normal termination of therapy. The only exceptions occurred when the therapy was prematurely terminated.<sup>39</sup> Rather, these previously autistic children have uniformly continued to demonstrate capacities and skills which, by any of the criteria applied to prodigy-ship, qualify them for inclusion in that group.

It is well known and documented that literary prodigies are very rare (if not altogether absent.)<sup>2,40</sup> Interestingly, the group of children retrieved from autism through Dyadic Repair contains several writers of remarkable and recognized ability. This group includes Jimmy, a 15 year old playwright, treated for several years in middle childhood and early adolescence. One of Jimmy's plays has been given a formal showcase staging in order to secure its production on Broadway.

Like the children retrieved by Tinbergen's admirable and dedicated "do-it-yourselfers", autists retrieved through Dyadic Repair unfailingly relate information, sights, impressions, conversations, nuances of experience and content of an astonishing degree of subtlety and accuracy. This material is drawn from their lives during the time when they were supposedly inert, profoundly disabled, blind and deaf, retarded, psychotic and defective individuals.

**A**s Feldman and Goldstein have proposed,<sup>2</sup> it is necessary for a complex and interlinked series of conditions and events ("coincidences") to occur in order to maximize the likelihood that a potential prodigy will, in fact, develop prodigious gifts. Then an even more delicate and fragile concretion of events must occur for that individual to come to emotional and personal maturity still functioning at a highly creative, innovative level. Similarly, it is necessary for a coincidence of internal and external events and realities, both emotional and biological, to convene in order for a child to become an autist. That the events producing autists and functional prodigies are closely related to one another is supported by a demographic oddity noted repeatedly by those working with either autistic<sup>41,42</sup> or prodigious children.<sup>43</sup> Given the rarity of child prodigies and the relative infrequency of autistic children, it is noteworthy that families containing a child in one category frequently contain a child belonging to the other group as well.

Clinicians and academicians have remarked on this peculiarity with some frequency. A small amount of speculation has been addressed to the strange and tragic nature of the occurrence of such a bi-directional deviation from the norm within a single

family. But, given the clinical experience which Dyadic Repair offers, it becomes clear that there is every reason that the autistic and the prodigy should be siblings: they are members of the same population, similarly enabled.

**I**n order for a child to build a defensive structure of the enormous magnitude and nearly impregnable quality constructed by an autistic, several factors must be present. Mother must be emotionally unavailable. This may be true for a variety of reasons predicated in complex circumstances like separation, physical or psychological illness, especially depression, professional pressures and so forth. Abnormal development in the child may be apparent from birth or may be noticed during the course of early childhood. But the child must have the necessary constitutional factors so that he has the capacity and tendency to respond to environmental stimuli with sufficient withdrawal to defeat mother's overtures successfully on a repeated basis.

Two additional factors are necessary to produce an autistic child. The first is rage: overwhelming, pervasive and unmitigated rage. Careful and unbiased observation of newborn and very young children reveals how completely humans are overtaken by rage early in their lives. But it is not yet customary to attend to the sophisticated perceptual and cognitive apparatus present (and in operation) at the time of birth. Exciting research<sup>44-51</sup> compels a careful reassessment of the competence of the newborn. Neonates record a vast array of stimuli, process it successfully and respond to it with enormous selectivity and precision. Neurobiological and behavioral investigation with primates shows us the impact of early infancy separation and anxiety on the crucial balance between the neuroreceptors responsive to endorphins and those responsive to adrenergic compounds in the brain. This research points out that the separation experience, and hence the anxiety level, of the newborn primate may "set the thermostat" for the continuing experience of safety or anxiety on a brain-based, neurochemical level persisting throughout life.<sup>52-55</sup> Couple this with an exceptionally high level of intellectual capacity, the second necessary factor for autism, add a reciprocally reinforcing cycle of communication failure between the child and the environment and you have the basic ingredients for an autistic child.

Lacking any one of these ingredients, or crucial elements, present in sufficient amount, one may see not a frankly autistic child; instead one may see a child who withdraws from the environment some of the time, yet is not always isolated and withdrawn. Indeed, just as a mild viral infection may not produce symptoms

striking enough to be noticed at the time but be remembered retrospectively, such withdrawal may pass all but unnoticed by the people around the infant. While present, such isolation may not come to professional's attention since it may be rationalized away, denied (if noticed) or not perceived at all. Other impairments less severe than autism may result from mutual withdrawal and bonding failure which like autism, persist for the duration of the infant's life. Some children, not gifted enough to be autistic, are merely retarded.

**C**learly an autistic child is not displaying wisdom by maintaining his autistic defenses. But the magnitude of such defenses is worthy of awe. In order to generate an intuitive "feel" for the necessary capacities which these children have, simply imagine what it would take for you to succeed in such profound isolation for even 24 hours. It is very difficult to imagine a child having the perseverance, perspicuity and sophistication to thwart all attempts at communication as successfully as the autist does unless we are dealing with an exceptionally canny and energetic child. And that is precisely the point. He may not necessarily be a wise child, but is clearly a very special one. The following cases are illustrative of the process of Dyadic Repair by which the hidden prodigy within the autistic child may unfold.

## **METHODOLOGIES OF DYADIC REPAIR**

Profound repair of early attachment deficits through Dyadic Repair is accomplished using physical, mental and affective interventions and strategies. While these strategies appear to depart substantially from conventional psycho-therapies based in and built upon the traditional psychodynamic model of psychotherapy the fundamental principals of this modality are in deep harmony with notions basic to object relations and attachment theory. The basic attachment and entrainment of mother and infant is seen as the foundation upon which all subsequent development rests. Early interference or derailment of attachment has vast consequences for this development. Repair of such a deficit is accomplished through a return to the assault accomplished in the experiential present tense through the participation of the transferential mother (or the actual mother in many cases) through the shared entry into an altered state by the partners in this work. Bonding deficits and impaired ability in the maintaining and sustaining of intimacy may be accessed and worked through as if the event were ongoing because of this altered state. No medication is used. Once this experiential

present tense is established empathetic resonance and the detoxification of the insult takes place. Since the deficit is part of a matrix of perception, many such events must take place with the subsequent repair of the ability of the couple to trust one another which working together in this way brings about.

**B**efore describing further the methodology used in Dyadic Repair, two caveats are in order. The first cautionary word pertains to the ease with which the altered state of affective and experiential present tense may be accessed and the difficulty inherent therein. The second pertains to the necessary intentionality of the therapist to assist the patient and is the more subtle and significant of the two. Like hypnosis, Dyadic Repair is a complex therapeutic intervention which uses a simple induction procedure. In hypnotic therapy, although dramatic, the induction of trance may be the least difficult part of the clinical work. But precisely because a powerful trance state may be so easily established there is a continuing possibility that untrained (or partly trained) persons may induce a trance state whose depth they cannot adequately control and of whose consequences they may be spectacularly ignorant. Having induced a trance, they may proceed to work within it regardless of the well being of the person in trance and may alter or impact upon systems and levels of integration and experience of which they are not even aware. Such ill-informed induction is clearly not in the best interest of either the data being sought or, more to the point, the trance subject.

The induction of the mutual alteration of state which allows Dyadic Repair to proceed is relatively easy to accomplish from a technical standpoint but, once accomplished, must be handled very skillfully if harm is to be avoided. The complexities are significant since two, rather than one, persons are being induced to enter a tremendously energetic state of experiential and therapeutic meaning and power. Their mutual interactions, their private re-living and working through which may lead to insight (and even transformational experiences) and their shared reality must be addressed and monitored carefully and intensively. The potential for leaving significant pieces of the newly accessed need and trauma states untended to is great while the opportunity to introduce new disappointment and difficulty is also great. Thus, great therapeutic skill and acumen is necessary if this work is to be carried out. Dyadic Repair is a transferable skill, but should only be carried out in careful and intensive supervision situations or by experienced, well-trained practitioners whose own background is rich in personal insight and understanding.

The unconscious holds experience without regard to time. Past and present carry

similar valences of reality. Thus, old conflicts are ever new in the deep layers of reality where they are stored. Until they are drained of their charge and either insight or some other change in experiential weight is introduced, they are as available for access today as at the moment at which they occurred. It is this stability of charge which allows the sometimes cataclysmic release of compartmentalized affect and experience in the company of a facilitating partner. But this cataclysmic release takes place for both partners in the context of the work and the delicacy and importance of handling this dual dynamic well is obvious. The second caveat rests in the fact that therapists pursue their work with the intention to “make things better”. Because of the power of the method and the gratifying results which may be achieved when the work proceeds well, there is a strong pull for therapists to believe that they can substitute for life-partners.

Regretting that a particular patient (with whom the therapist feels an alliance, or a countertransferential bond or a genuine caring concern) lacks the partner necessary to effect the necessary retrieval and long-term continuity which is absolutely essential to Dyadic Repair, the therapist may allow himself to be seduced into being a Dyadic partner. The reasoning which accompanies this error may be based in great affection, but it is a seduction of both therapist and of patient nonetheless. There may be actual battles and a partner may find himself physically restraining the identified patient (or vice versa) as the protest and pathological equilibrium is struggled with. Clearly, this level of contact and intimacy is not appropriate under any circumstances between patient and therapist.

**I**n fact, in one lamentable situation, an experienced male therapist allowed himself to become so far removed from his best judgement that, in his center, it is the patients’ mothers who are held — in a full body embrace with the therapist lying atop the child’s mother’s body — in what passes for therapy. The clinician has allowed this seduction of his intention to proceed to a degree which makes identification of the problem fairly simple from the position of objective watcher but seems difficult for him.

In fact, therapists are ill-prepared for what this contact may bring since the intensity of connection with patients who are engaged in this work is rarely experienced in the context of therapy. Thus, careful monitoring of countertransference and personal distortions in general is, if possible, even more vital than in any other type of therapy. Further, should the therapist succumb to the temptation to enact the role of rescuer for a patient, several consequences follow. First, there will be an eventual

abandonment which, unlike the death of a parent or spouse, is predictable and necessary. The basic invitation to trust the safety of this connection, offered to repair a failed early connection is, in essence, an invitation based in a lie. Unless the therapist plans to adopt the child patient or marry the adult patient, there is no way in reality for the continuity of the relationship to be maintained which must be implied by the intensity of the connection. Manifest content to the contrary notwithstanding, the therapist and the patient who engage in therapeutic rescue with the therapist acting directly as the patient's holding partner are playing out a fantasy of "forever connection" which cannot and should not be enacted. Rather, this fantasy should be worked through for eventual termination and healthy separation.

**A**dditionally, this is not "blank screen" therapy. Both partners in a dyad are in treatment. Should one of those partners be the therapist, who then is conducting the therapy? In what way is it then safe for the patient to unfold the basic, primordial realities of his attachment life if the agenda of the therapist is to reciprocally do the same rather than to foster and facilitate the patient's growth? What can it mean for a patient to take on the role of reciprocal healer for the therapist instead of reciprocal healer for the partner of affect and life circumstances? When a therapist confuses the wish to help and the need to fuse at the unconscious level this may result in a strong rationalization of the "rightness" of the therapist becoming the Dyadic Repair partner. Ultimately, disappointment and abandonment must result when appropriate contours of behavior and intent are violated by this violation of therapeutic scruples. No amount of good intention will change this basic reality.

The actual therapy is carried out either with a family-based group or with a group of family based groups. The latter, while desirable in terms of efficient utilization and enhancement of intensity and efficacy of the therapeutic effect, is the more difficult for the therapist to carry out since it multiplies the complexities mentioned above. If it can be handled successfully by the therapist, however, it offers the members of each family based group the opportunity to deal with the basic attachment and intimacy issues which are being addressed by the therapy in the context of a helpful group setting. At the beginning of a Dyadic Repair session, mother and child arrange themselves physically in such a way that they can safely and comfortably have their arms around each other and look reciprocally into each other's eyes. Note that the identified patient may be of any age and that the mother may be, in fact, the transference mother and thus have the role of spouse, parent, sibling, fiance, etc. Thus the terms "child" and "mother" refer to emotional and affective states of

attachment and need rather than demographic and relational realities. In fact, because of the profoundly reciprocal and mutual nature of this work, the reality of “mother” and “child” may shift radically in the course of a session, or do so several times, so that functional relationships may alter the affective reality of who is the mother and who is the child within the course of the work.

Especially when the identified patient is an autistic or an adolescent, the task of establishing this physical reality of safe holding and mutual gaze may be very difficult to achieve. In fact, this battle (and it may indeed become a pitched battle) is very much a part of the therapy in which the child tests mother’s intent while mother demonstrates whether she has sufficient intensity in her requirement for contact to allow her to persevere despite the obstacles thrown in her path. These obstacles can, in the most extreme cases, include biting, punching, hitting, scratching, urinating on mother, trying to pull her hair and poke her eyes, etc. Even when the child is a massive adolescent drug abusing male and mother is a sub-5 foot woman, if she truly wants to hold the child he will ultimately allow her to do so but only *after* he has made sure that she *really* means it this time. Since this first encounter can take several hours I usually allow open ended time in my office for a strongly energized first session. It is predictable that there will be enough resistance to make the ordinary 45 minute time slot of my office hours quite irrelevant and, in fact, inappropriate. It is vital that the therapist’s commitment match that of the parent so that a Dyadic Repair session is not allowed to end because of the time rather than because a rapprochement has been reached. But before rapprochement can be reached, it is necessary that the connection, now achieved through the means of this intense demand for intimate contact, rather than superficial or failed contact, be used to bring about change.

**T**ypically, I will ask the non-identified patient, usually the mother, to begin the next stage of Dyadic Repair by telling the child how angry mother is with the child. Bear in mind that this may mean a middle aged man telling his depressed wife how angry he is. Gender and age are not related to the dynamic parent and child relationship. By liberating affect, by being encouraged to give voice to real feelings brought about by the dis-ease which afflicts the system, it becomes safe for the child to reciprocate. Child can feel mother, regardless of the content of mother’s communication, and this induces trust. But more than simple modeling is taking place. In fact, there is a significant stimulus barrier between the bearer of the overt symptoms (“child”) and his partner’s feeling state. Communication is disastrously poor. Affect communication is either severely distorted or absent alto-

gether. So raising the intensity of communication has the advantage of overcoming the stimulus barrier. In other words, once affect is felt, it is detoxified since the toxin is the lack of empathetic resonance, not the anger (etc.) itself.

**C**linically what happens is that as intensity of affect liberation is increased, the child begins to hear the mother's pain and distress as genuine experiences, not just as poor excuses for mother's lack of good nurturing. The child begins to experience the mother's affective state as having equal meaning and significance to his own and he begins to feel true empathetic resonance for mother. With empathetic resonance, healing begins. Before this point is reached, however, the modeling which mother has been doing provides the opportunity for the child to liberate his own affect. "You think you have a reason for anger? Well, it's nothing compared to mine! Listen to this" seems to be the rationale of release. What floods out is, typically, the repressed, withheld and denied anger of the child.

Overcoming the stimulus barrier of defense and denial of the mother through its sheer intensity and amplitude, this wave of distress causes a curious reciprocal movement in mother. She feels what it is like to be the child. These people are, after all, bound in love and concern although their relationship may be at this point a highly corrupted and disordered one. But, at base, these two people care enough to be together in the office for some purpose which includes love at some level and for some agenda which includes healing at some level. And this process of high intensity communication of "what it is like to be me heard by the very person most closely bound up in both my pain and her own" stimulates the detoxification of this pain.

It is as if mother becomes a container for the rage, despair, disappointment, fear, etc., which is so enormous that it overwhelms the child until it is given to mother. Once that happens, there is a rudimentary bond of trust and an episode of repair both experienced and recorded for future processing. And this process is repeated over and over and over again during the course of this intense and efficient therapy. The interventions of the therapist take many forms. Assessing visually the non-identified patient (which usually means sitting behind the patient to monitor the pulse, respiration, pupillary dilation and other signs of state in the mother) the therapist is able to use a combination of role-playing articulation of the unspoken feelings (paradoxical and direct) of either partner. More traditional questioning and interpretation, exhortations for increased intensity through repetition and a host of other techniques are also used.



The simple act of raising the volume of communication between parties in a controlled environment of safety has a rather interesting and beneficial effect. The increased volume seems to act as a “carrier signal” for the reality of meaning in the affect communicated no matter what the affect is. Following this high intensity development of emotional sharing and the development of empathetic resonance between these two people (often surrounded by participatory family members), a rather sudden and dramatic rapprochement usually takes place during the course of the session. Raging and distant people now gaze lovingly at one another and speak meaningfully of their feelings. Previously non-verbal persons may speak of their internal pain and longing. An angry adolescent lies contentedly in mother’s arms and confesses that he believed that mother no longer loved him.

**I**n a group setting, family-based units join each other in a discussion which includes children and adults. Inclusion in the group is based solely on the need of one or more members of each family-based unit to receive treatment because of significant early attachment deficit leading to psychopathology. Thus, identified patients in each family unit may be of widely varied ages and diagnosis. Autistic children and depressed adults, parents, siblings, spouses and other family members comprise the group. Age, stage, experience and wisdom base can be shared. Mutual support is offered, received, sometimes withheld and worked through as in any other therapy group. Groups generally take approximately 3 hours once a week so that ample time for a Dyadic Repair experience is allotted as well as group discussion. Although a co-therapist is desirable, a single therapist can conduct a Dyadic Repair group with up to nine families. A minimum of three families is ideal.

Often family groups will spontaneously bring other members of the family into therapy beside the identified patient. Since the family system is, in fact, the patient, this indicates a successful therapy underway. It is not uncommon for two or more subunits of a family to work in Dyadic Repair simultaneously during a group. Since the fee structure is agreed upon per family attendance at the group or the private session, there is no penalty for more people in the family receiving assistance and this acts as a positive incentive in some cases since multiple therapy foci for the same cost is perceived as a “bargain”. It is also useful to note that the use of psychoactive and neuroleptic medication is strikingly reduced through this procedure and that seizure control for self-stimulated seizure activity (which may appear identical to other seizure conditions) is accomplished without pharmacological means in many cases.

When Dyadic Repair takes place in the context of private session, a minimum of two 45-minute sessions without an interruption is allotted. The conduct of the therapy is much the same with intense involvement followed by rapprochement and discussion (if time allows). Whenever possible, no dyadic repair session is allowed to conclude without a rapprochement since the experiential distress caused by an unfinished session is great and the dynamic harm to the system may also be great.

## CASE HISTORIES

### Billy

Billy, a 4 1/2 year old, was brought for initial consultation by his mother Sandra and his father, Bill, Sr. Billy was a completely non-verbal child whose communication was echolalic and free of meaning. He verbalized almost continually in a high-pitched, sing-song voice, but his speech consisted entirely of repeated commercials he had heard on TV. Neither teachers nor parents could find any relationship between these verbal productions and events in the environment. Billy was well nourished and normally developed except for a vacant, slack look. He had been found to be mentally retarded, although precise evaluation was almost impossible since he was totally non-participatory and did not follow instructions or suggestions.

On the recommendation of his pediatrician he had been placed in a pre-school for children with developmental difficulties. A "token economy" environment using frequent "time-out", (i.e., enforced isolation) had been chosen as his school placement and his parents were instructed to follow a similar regimen at home, which they did.

Billy's birth had been tumultuous. He had a highly traumatic postpartum period and no history of successful attachment. He was born by emergency *Cesarean Section* after several days of unproductive labor as a face presentation. When some obstetrical point of no return was reached, a Cesarean was abruptly performed with no prior discussion of this possibility with either Sandra or Bill, Sr. Following the birth, the baby was presented to his now exhausted and hurting mother immediately upon her return from the recovery room. Unwilling to see or hold him, she rejected him, screaming that she never wanted to see him and ordering the nurse to "Take that thing away!" When Billy was re-presented to her 24 hours later, Sandra was ready

to accept him. The nurse reported that Billy had screamed almost continually during that 24-hour period of separation from his mother. Upon the second presentation and thereafter, Billy never molded or cuddled, refused to make eye contact, did not respond to caresses or other indications of affection and keened almost continually in a high-pitched, whining wail that continued for hours at a time.

Following the paradigm which holds autism to be a failure of attachment in a vulnerable child and therefore necessitates treatment by repair of that ruptured or absent attachment, I chose to initiate therapy and simultaneously conduct a diagnostic interview. I asked Sandra to hold Billy, demand eye contact and enter into an intense and highly charged communication with her child. In the session, a substantial amount of early trauma was spontaneously retrieved and released by Billy in the context of intense and reciprocal communication with his mother. He verbally and explicitly presented this material while abreacting it in the experiential present tense. Once he began to share these experiences, he used meaningful, grammatically correct speech, recounted perinatal events accurately, told his mother explicitly that he believed that the extreme suffering he had experienced during birth was her fault since it had been engineered by her. He also said clearly that he was still frightened of both her power and her failure to protect him in the past, in the present and, potentially, in the future.

**A**fter both the abreaction of the early trauma and the sharing of its current and past meaning for him, Billy asked for a drink of orange juice while looking directly at Bill, Sr. His father, who had played no active role up to this point, responded with neither visible emotion nor surprise when his totally non-verbal son now calmly and competently asked for a drink. Noting that there was no orange juice he suggested water instead. Despite the characteristic tantrum response which Billy had previously shown if any of his wishes, no matter how minor, were thwarted, he calmly accepted this substitution and waited patiently while his father left the room for the water. Meanwhile, he sat snuggled comfortably in the curve of his mother's lap appearing peaceful, still and contented.

When Bill, Sr. returned, Billy carefully held the cup and sipped the water while looking intently and lovingly at his mother's face. He verbally and gesturally offered her his water. Mother and son gazed lovingly at each other while the cup was held by them both and handed back and forth for small, slow sips and long, tender looks.

During this process, Billy accidentally spilled a small amount of water. He became terrified and retreated into his former autistic behavior. Sandra seized the opportunity for further work and there was another abreactive release of additional early trauma and abandonment followed by another tender and loving rapprochement. After this piece of work had been accomplished, during the rapprochement phase, Billy looked deeply into his mother's eyes and said, clearly and distinctly, "I love you, Mommy!" His mother began to cry and responded, "I love you, too". I asked whether Billy had ever said this before and Sandra and Bill, Sr. both affirmed that he had never before spoken meaningfully, never allowed himself to be held for loving and never made meaningful eye contact.

**S**andra and Bill, Sr. left, apparently determined to pursue Dyadic Repair with their son. Within two days, however, there was a marked shift in their attitude. They called to say that there would be no further visits. Sandra denied that there had been any utility to the session at all and characterized it with considerable outrage as a "waste of time and money". Since the session had been videotaped, a copy of the tape was offered to the family free of charge. They angrily refused the offer.

Billy was returned to his school to follow a stultifying and punishing regimen. He was also returned to the category of "autistic, retarded and non-verbal". Billy is a child whose needs and pain thus do not have to be integrated by his family, but whose unacceptable behavior can, instead, remain the focus of attention. Billy's mother is free to maintain her perception of him as she needs it rather than as he is. Positive behavior and communicative speech have become non-events in the life of the family since they provide intolerable conflict with the unconscious needs and wishes of Sandra and Bill, Sr.

In fact, in about 50 per cent of the families of frankly autistic children with whom I have worked, this dynamic need, deep, but buried far outside conscious awareness, has resulted in early sabotage of treatment. This has included repeated failure to keep appointments, refusal to pay the agreed-upon fee (or to fill out forms for reimbursement when there was no fee to the family), early withdrawal from therapy in spite of (or because of) dramatic improvement by the child, destructive negative responses to the successful communication of the child, sudden decisions to institutionalize the child, etc. These failures may prove intractable to therapeutic and other intervention.

Clearly, then, there is an unconscious need on the part of some, perhaps many, parents of autistic children to potentiate their withdrawn positions, however disastrous the consequences of such withdrawal might be for both family and child. The reality of such deeply held resistance to change and growth is well known to family and child therapists in other contexts. By getting better, the identified patient may destabilize the entire family system (and be pulled out of therapy) if the needs being fulfilled by the symptoms as expressed by their current repository are not successfully addressed.

## **Penny**

Penny<sup>36</sup> is a 14 year old white girl born in the United Kingdom. Her gestation, although full term, was marked by several long periods of fetal inactivity. Helga, her mother, consulted with her obstetrician during these times to find out “whether or not the baby was still alive.” The pregnancy was otherwise unremarkable. Penny’s birth and early development were reported to be normal except for repeated mention in the obstetrical records that Helga was “quite depressed”. No further interaction with Helga’s emotional state was sought and no consultation was offered.

**M**ax, Penny’s father, is a successful academic, Helga a highly accomplished and educated artist. Penny’s conception was the source of bitter dispute between Max and Helga. Max did not want children: before Penny was born he demanded (and received) a commitment from Helga that “the baby would in no way interfere with my life”. Consistent with this agreement, when Penny was 6 months old she was left with a succession of unfamiliar nursemaids while Helga and Max went on a 4-month sabbatical. When they returned, Helga felt that Penny was “not there”. Her growing conviction that there was a serious problem led Helga to take Penny for evaluation at several major University medical centers. Penny was repeatedly assessed as “Autistic, congenitally blind, congenitally deaf and profoundly retarded”. Previous history and assessments of normal health and development were discounted by the professionals evaluating her. Neurologic assessment showed a profoundly abnormal EEG and a seizure disorder. These findings were replicated by child study teams at two other major European medical centers.

Upon Penny’s diagnosis, Max divorced Helga because, “a retarded child is the last thing I want or need”. Helga received on-going assistance from Lisa, her own mother, in the difficult task of caring for Penny. At age 4, Penny was placed in a

day treatment program for autistic and retarded children. She remained there for 5 years. Behavior modification, nutritional, dietary and educational modalities were tried without success. By the time she was 9, Penny had developed severe disuse atrophy in all limbs, was totally non-verbal, appeared completely unresponsive to verbal, visual and physical cues, was insensitive to pain, incontinent of both urine and feces, babbled and drooled continually and had frequent seizures which could not be controlled by medication. No areas of intact functioning were observed. The director of the program pronounced her a "total treatment failure" and advised her mother to seek out Dyadic Repair as "the only remaining alternative".

**A**ccordingly, Penny, Helga and Grandmother moved to the United States so that they could begin a course of Dyadic Repair. Interestingly, they arrived in this country without making any prior contact with the therapist and angrily demanded that the therapy begin during the course of the initial phone contact.

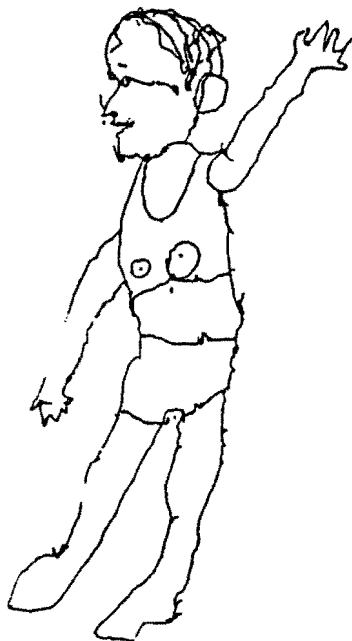
Over the next 4 years, eye-contact, bladder and bowel control and response to verbal cues were established during the course of Dyadic Repair. Seizure-inducing self stimulation was eliminated and clear responses to verbal, visual and physical cues were forthcoming. Penny still appeared to be a profoundly retarded child. Her therapist maintained that she was not. Helga became enraged with both the therapist and Penny. During one particularly explosive session, Helga grabbed a piece of paper and a pen, thrust them at Penny and screamed, "Well, if you're so goddamned smart, prove it! Write!"

Penny did.

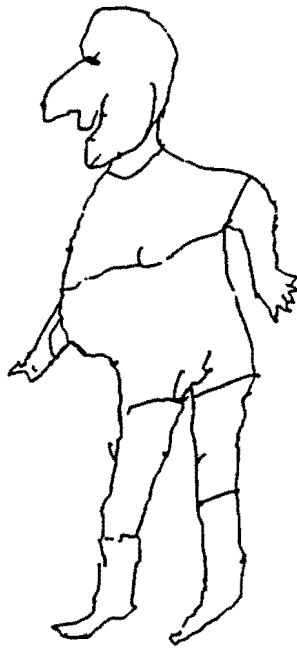
Over the next year, even though she still refused to speak, Penny made it clear through her writing that her presentation as a blind, deaf and profoundly retarded person was motivated by rage, fear and a primitive, persistent belief that by remaining totally dependent she could bind her mother to her forever. She wrote about the period of early separation from 6 to 10 months saying that she "was just beginning to make words" when Helga left her for 4 months. With the concrete logic of a baby she concluded that her speech must have been the cause of the intolerable separation and felt that she "must not speak again". Although she never saw any of them again, she has written about her nursemaids during that 4 month period, naming and describing each of them accurately. This supposedly blind and deaf

child described both the visual and linguistic characteristics of each caretaker. Thus, the diagnosis of congenital blindness and deafness was totally incorrect although it had been independently reached at three different University medical centers.

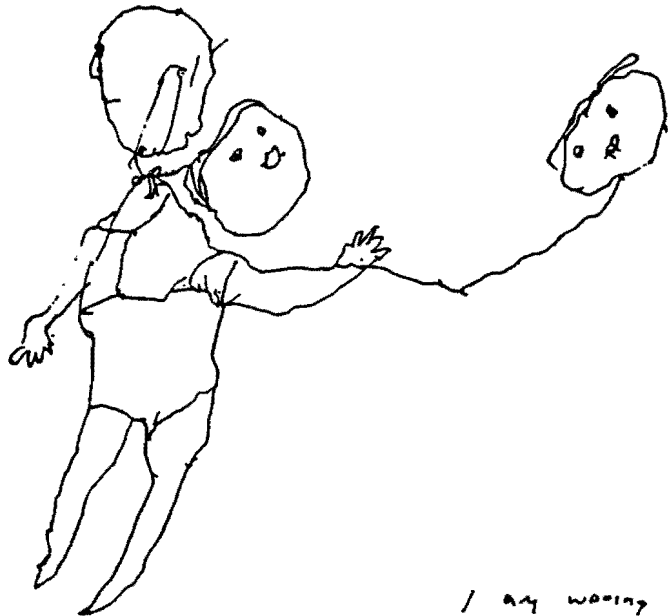
When she was 12-months old, Penny had accompanied her parents for a 6-month stay in Italy. She wrote in accurate detail about that stay and maintained that her ability to read and write Italian came about because she learned it during that period. In addition to English, she also reads and writes German (Helga's native language), Yiddish (of which both her parents and grandmother are ignorant) and French. Careful probing made it clear that, although she was troubled that we now knew she could do it, Penny had intuited a great deal of upper-level mathematical reasoning. A High School math book had been left within her visual field several years before and, reading parts of it upside down, and in great fear lest anyone discover her at it, she spent about 30 minutes reading the book. That exposure, before moving to the U.S., constituted her entire math education. Yet Penny can do most of the math taught in High School and a good bit of what she would be taught in a first and second year college mathematics curriculum.



*Figure 1. Draw a figure (woman).*



*Figure 2. Draw a person of the opposite gender (man).*



*/ my waving one head*

*Figure 3. Draw a picture of yourself.*



At my request, Helga asked Penny to execute a series of drawings. She drew a person (Figure 1), a person of the opposite gender (Figure 2), and a picture of herself (Figure 3). While Penny's speech was still intentionally limited, she wrote voluminously. I have observed her write: there is no doubt that it is her writing which is represented in these samples. This is what Penny writes about her autism:

*When scholarly doctors words describe about autism they are full of dopey garbage. What causes autism is sorrowful wooden soon after birth or during birth despair about door closing danger.*

She wrote an essay called *Autism and Me* in which she tells us:

*Since society angrily and destructively wages wars we are angry new generations producing who are degraded and angry and yelling to be heard. A dominant weary and impatient parent gets a dominated weary and wordless child. I came into world and universal and family unrest and wearily deadened my answering impulses with a dormant and protective soul or spirit and wordlessly yelled in despair.*

*One day an angel named Geraldine saw and heard wordless and desperate desire to words dedicate and dearly said good and necessary searing words. I was dead and weary and an analogy would be a weary wordless winter night — dark, cold, wounded desolation. Seeing weariness would want comfort, words would want a voice, darkness would need light, wounds would need healing. Another angel did what was necessary — mother.*

At age 13, after 4 years of therapy, Penny still presented the appearance of a profoundly retarded child. She would neither speak nor make eye contact. She still drooled and grunted, shuffled rather than walked and held her body in stiff and peculiar ways. But the secret was out: every night, when Helga was asleep, Penny would sneak out of bed to read the books and encyclopedias so easily available in her house. She took extravagant care to return them in such a way that no one could tell they had been touched. When I asked her what she wanted to do academically, openly and without hiding, she wrote that she wanted to read Dostoyevsky's *Crime and Punishment*. I asked why she had chosen that particular book and her answer

was, "Dostoyevsky has written a book about wooden feelings. I want to read it to help my wooden feelings come alive." As she read the book, she spontaneously wrote essays and poems about it. After finishing *Crime and Punishment* she wrote the following poem:

*DOSTOYEVSKY: A Poem*

*I am deciding to only sow seeds of soulful  
Sorrow and will harvest them all tomorrow  
I despair despite what devouring oafs say  
Of the everyday world we inhabit today  
I don't pretend we can cancel out crime  
I won't pretend I am sane all the time  
We go on our way one day at a time  
We won't care over sin to sigh  
Or sorrowful slow justice to cry.  
I describe our plight as our world might  
As woe and sorrow would some fight  
But I believe God soon will give  
Us each another chance to live.*

Penny's intellectual depths have hardly been plumbed. Her emotional and behavioral deficits made standardized testing instruments completely inaccurate. Her early and exceptional mastery of languages, artistic control of English and level of skill attainment in diverse fields are exceptional. Coupled with her extraordinary memory these attributes point compellingly to unusually rich and diverse abilities. If nothing else, her fluency in reading and writing several languages despite minimal exposure to them would be prodigious. But, as her writing makes clear, there is more to Penny's intellect and promise than a mere savant-like skill in foreign languages.

Although simultaneously inspiring, shocking and distressing, Penny's case is by no means unique. Among those children whose mothers have been willing to commit themselves and their children to the very difficult, demanding and forbidding task of retrieval through Dyadic Repair there are many "Pennys." In cases where retrieval has progressed far enough to allow us to see the intellectual and other capabilities of the child, we have been privileged to begin to see the child of remarkable abilities who lies folded within an otherwise nearly impregnable cloak of withdrawal. In how many of the total population of autistic children does a child like Penny lie hidden? No one can yet say with certainty. I believe the numbers are great.

## Tammy

Tammy was brought to see me late in the academic year when she was 13. She was a tall, well nourished girl quite advanced in sexual development. She was poorly coordinated, walking and gesturing very awkwardly. Tammy spoke only in guttural and distorted grunt-like sounds except when shouting out long strings of perseverative “clang associations” to names which she liked. These were delivered in a strident, bark-like bellow which was interspersed with wild, inappropriate laughter. She appeared to have an athetoid disorder, all limbs, head, torso and neck writhing constantly. Her face contorted continually and her tongue protruded in a poorly controlled and unappealing manner. She exhibited upward eye rolling and fixation of gaze when her head and eyes were not involved in the generalized athetoid movements.

Tammy had been hospitalized at a highly-regarded institution for schizophrenic children from age 8 to 12. At 12, having reached the upper age limit of the school, she was released to her parents’ care and placed in a day school for emotionally disturbed children. Residential placement had been made on the basis of therapist recommendations since she was destructive and nearly impossible for her parents, Robert and Sally, to manage. Her brother, Alan, 4 years her junior, was exceptionally bright, well-functioning and was said to have “no problems” by his parents.

**R**obert had experienced a severe depression around the time of Alan’s birth which had resulted in his being out of the home (although not hospitalized) for several months. Sally was alone with a newborn infant, a psychotic daughter and had a husband whose depression threatened to end the marriage at any moment. Although denying that she was depressed or overwhelmed at any time, Sally did admit that it had been an exceptionally stressful time for her. She volunteered that “perhaps I had less to give to both children than I would have liked.”

Tammy’s development was perceived as normal for the first 4 years of her life by Robert and Sally. When she was almost 4, she visited a dentist who observed that although Tammy spoke, she spoke only in fragments of TV commercials. He suggested that she “might have psychological problems.” Her parents were enraged and refused his referral to a child study team with anger, consternation and dismay. Subsequent to this interaction, however, Sally was forced to admit that he might be right. Tammy was brought to a child study team for evaluation. She was found

to be psychotic with an I.Q. of approximately 70. "Infantile Autism with Psychotic Features and Retardation" was diagnosed, although she had walked early and, as noted above, *appeared to her parents* to have good receptive and expressive language. This is noteworthy in light of the fact that by age 4 her expressive language was, in reality, almost nonexistent.

**T**ammy was placed in a therapeutic nursery school for autistic children where she did very poorly. At age 8, after several years in special education, she still could not read the alphabet. Upon leaving the residential institution at age 12, Tammy could only read with difficulty at the pre-primer level. Most of her waking hours were spent either in psychotic reverie (with a fixed and inappropriate smile on her face and self-stimulating laughter) or in loud screaming fits. These episodes typically lasted 6 to 8 hours and seemed to have no relationship to external events either in onset, severity or duration.

Tammy's early development, although initially described as "completely normal" was, in reality, severely disturbed in a variety of areas. She was fed by bottle with the introduction of a variety of spoon-fed soft foods by about 6 months. Tammy fought every mouthful with head turning, screaming, regurgitation and flailing: each feeding was a prolonged and painful struggle for dominance. She was essentially force-fed each meal by one parent while the other pinioned her.

Her sleep was seriously disordered with bouts of arousal to screaming and flailing several times each night. Since Tammy would awaken fully and then enter these rage-like states, these were neither episodes of *pavor nocturnis* nor nightmares.

Tammy was exceptionally destructive of clothing, toys, books and, unless watched constantly, her brother. The family eventually had to move from their apartment on the 20th floor of a high-rise building because Tammy created a serious safety hazard by throwing objects over the balcony railing and out of the windows so often. Tammy was unable to engage in play with other children since she was consistently dangerously violent toward them. She was similarly a threat to her brother Alan's well being. Sally recounted that she was "friendly at first when the baby came home," but when she realized that all of her clothes, toys, bottles, furniture and other personal objects had been given to the baby (and replaced by a new bed, clothes, toys, etc.) she became "very angry and started to be mean to him." This was noted by both Sally and Robert but no significance was attached to this

change in Tammy's behavior.

After Tammy had been in therapy with me for 1 month, Sally brought in a prescription blank for me to sign. When I inquired for whom this medication was intended, Sally informed me that she had "forgotten to mention that Tammy is taking 200 mg of Mellaril 3 times a day." This medicine had been prescribed to control the eye rolling and screaming (but with little success) about 1 year earlier. It had been steadily increased until it had reached its current very high level. Against the objections of both parents and school, I discontinued her medication and since then she has been medication free.

Tammy was the first born child in a marriage described by both partners as "absolutely perfect until the children came." Sally was rigid, tense, domineering and overly controlling, meeting every situation with a bitter and caustic cynicism which spared the feelings of no one. Her biting wit was accompanied with an equally bitter smile which was as inappropriate as Tammy's. She felt that she had been an "absolutely perfect mother" and proclaimed (in Tammy's presence) that "Tammy's autism has absolutely nothing to do with her family. What she got from us is much too good considering what a piece of s— she is!" Sally openly expressed how much she hated her daughter and said repeatedly in her hearing that both she and Tammy would be better off if Tammy were dead.

**R**obert, a public school teacher, easily matched his wife for intensity of disdain and for bitterness. Jealous of everyone whom he perceived to consider themselves his "betters", he resented every aspect of his life. He begrudged everyone else whatever he believed they had or enjoyed which he did not. Although he spent a considerable amount of time with both his children, he was remote from them, hurtful when he spoke and caustic in a diminishing and abusive way. He was browbeaten by his domineering wife, but appeared to have no conscious awareness of this. Instead, he abused and attacked his children continually. Where Sally wore an inappropriate smile, his expression was frequently a self-effacing smirk when delivering his blows to the self-esteem of his children with deadly accuracy. With great pride he recounted stories of his daily work life in which he delivered similar blows to the children whom he taught. He seemed to take an active delight in the humiliation and discomfort of his students and of his own children. Interpretation about the impact of this type of interaction seemed ineffective.

The first phase of therapy was consumed with resistance by Tammy, Sally and Robert. Each session consisted of Tammy writhing, grunting, screaming and perseverating while Sally and Robert alternately heaped abuse on all doctors, psychiatrists in general, me in particular, children as a group and Tammy as the worst child anyone had ever had. Attempts to get Sally to confront either her rage or Tammy's were singularly ineffective until about 6 weeks after therapy began. Tammy was about to be ejected from her special school situation for being totally unmanageable: she screamed an hour each day on the bus to school, and hour on the way home and all 6 hours of the school day. Since Sally and Robert did not know of any alternatives to this placement, the letter threatening to eject Tammy evoked both fear and desperation in her parents. I urged Sally to tell Tammy what she was feeling and, this time, she cooperated with my request. Although Tammy was difficult for Sally to hold since she writhed, fought, spat and screamed continually, nonetheless, during this first effective Dyadic Repair session Sally's rage and despair lent her almost preternatural strength.

**W**hile sitting astride the thrashing, screaming, drooling girl, in a near frenzy Sally shared with Tammy 13 years worth of disappointment, sorrow and fury over the fact that her daughter was not someone whom she could love and who could love her. Tammy screamed wildly for the first half of Sally's diatribe. But then she seemed to calm as Sally went on pouring out her anguish. Her eyes stopped rolling and her body became nearly still. At the end of approximately 45 minutes of Sally's near-hysterical release, Sally collapsed into tears of exhaustion and anguish. Tammy's face took on a focused and alert look for the first time in my experience of her. Taking Sally's cheeks gently in her palms and turning Sally's face toward her own Tammy said, "I didn't know you really loved me!" She proceeded to tell her mother how often she had tried to hurt her by her behavior over the past 13 years. Her speech was clear, her grammar was excellent and her vocabulary was exceptional, especially considering that she was supposed to be organically retarded.

In session after session, Tammy recounted her early disappointment with mother. She shared her long standing conviction that the soft foods she was being fed as an infant were her own vomitus returned to her by a hostile and hateful mother. She told Sally that she felt sure that Sally wanted to kill her and that Tammy destroyed her toys, etc., in order to get her mother to tell her that she would never destroy her. In short, Tammy reprocessed her childhood by borrowing ego structures from her now-available mother. By the end of 2 months of therapy it was

abundantly clear that Tammy was far from retarded. Neither of her parents could maintain that to be the case any longer. Sally and Robert abruptly informed me that therapy would be interrupted for 8 weeks since Tammy was being sent to summer camp. This decision had not been discussed with me. The session after this announcement was our last for eight weeks.

When Tammy returned she was no longer writhing, but her intellectual and emotional gains had been lost. It took 2 months of both private and group sessions each week to regain the trust which Sally and Tammy had begun to experience in each other prior to the summer break. But 2 weeks after that, Sally reported with a face glowing with joy that Tammy had come into her bedroom that morning for the first time in her life to ask for a kiss. With tears streaming down her face she announced that for the very first time in her life she had a daughter to love. Tammy appeared wooden and impassive during this account, yet her work in that session was full of emotional words and high-level ideation at a level I had never observed in her before.

Shortly thereafter, I requested that Sally and Robert create an appropriate academic program for her since Tammy was being educated in accord with her tested IQ and functional level rather than with her real potential. I asked that she do a book report as her first assignment. Sally asked what book she should read and, on intuitive impulse I said, "The Diary of Ann Frank." Tammy screamed for two days straight but then read the book at a single sitting. Without being told what a book report consisted of she spontaneously wrote a two page essay relating her own previous imprisonment to that of the imprisoned Dutch girl. This essay was touching, eloquent and linguistically impressive.

**F**ollowing that stunning success, I assigned a series of academic exercises as well as social ones. Tammy became involved in group activities for normal children her age (with occasional difficulty, it is true) such as social clubs and youth employment opportunities.

Her improvement was steady. Within another year the school had placed her entirely in mainstream classes where she was being given academic work on, and above, grade level. By the end of her first year of therapy, she was regularly making the Academic Honor Roll, scoring no grade less than 85 with most 93 or above.

But as Tammy improved, her place as symptom-bearer in the family was now vacant. Alan was now perceived as a deprived and desperately unhappy child who had been

seriously neglected while his older sister's needs were attended to. Without discussing it with me, Sally and Robert began bringing Alan to the Dyadic Repair group which they attended with Tammy. As Alan's loneliness and disappointment became available for working through and repair, his sullen and isolated behavior improved greatly. Once again, there was vacancy for a new symptom-bearer to fill. Robert became autistic.

**D**eclining rapidly from a bitter but loquacious man, Robert became remote, isolated, ritualized, obsessive and compulsive. He was preoccupied with repeated and stereotyped behaviors, mute and apparently unable to function at an intellectual and emotional level higher than that of a 4 or 5 year old. He was hospitalized under the care of a colleague. During and after his hospitalization, Sally said that she wanted a divorce since she did not want or need more problems. Because she would not allow him to come home, upon discharge Robert returned to his parent's home.

Robert was the younger of two children 4 years apart. Throughout his childhood, his older sister was seriously disturbed and was the object of intense rage, therapy, concern over drug abuse, and violent fights. To survive, Robert adopted a strategy of invisibility: he made no demands on his parents, never told them how he felt and bitterly waited for them to notice how unhappy he was. For example, although very myopic, when his glasses broke he walked around for 2 years without mentioning to anyone that he could not see. The fact that his parents neglected to notice and correct the problem served for Robert as a demonstration of their lack of caring. His anguished, bitter denial of his pain over this is very poignant. Although his childhood had been a seriously disordered one in which he was severely neglected, nevertheless, his parents were able to give him some emotional nourishment at the time he was released from the psychiatric hospital. Robert was able to regain his former level of functioning and persuaded Sally to accept him into the home again.

Sally and Robert began to address some of the very serious areas of dysfunction in their relationship, although throughout their 20-year marriage they had remained steadfastly unaware of them. They engaged in bitter, recriminative, but eventually productive therapy on a weekly basis, in addition to Tammy's therapy. Progress was slow but continuing so that within 8 months of Robert's hospitalization the marriage appeared stabilized and interactions with both children had improved significantly.



With time and therapy, Robert, like Tammy, has moved away from the position of symptom bearer. Currently, no one in the family carries the exclusive burden of autistic or symptom bearer. It is true, however, that the family in the aggregate, and each of its members individually, are seriously disturbed. Tammy continues her academic success in a High School program consisting entirely of mainstream classes. She accomplishes the High School curriculum at the Honor Roll level with great ease, as well as additional assignments designed to challenge and enrich her. Tammy is a highly gifted child whose area(s) of exceptional talent are only now beginning to unfold. What her particular areas of genius will be is not yet clear, but she is a child of considerable gifts which can be expected to come to fruition in the next few years. Her writing and analytical thinking show great promise and may well become the focus of her efforts.

Tammy secured a part-time job on her own initiative when school started in the Fall of 1990 and conducted herself well, although a company merger left her without a job after a few months. Social successes, too, continue to mount, and her family is making plans for her to go to college within the next two years.

## CONCLUSION

**A**utism masks and distorts the child's unique and powerful capacities, it does not destroy them. Such children can, given the repair of the basic fabric of the earliest maternal-infant bond, be returned to functioning which is exceptional in the same way that any successful child prodigy's functioning is exceptional. Based on what we know of the incidence of autism and of prodigy-ship, it seems likely that there are, *in toto*, more autistic child prodigies than non-autistic ones in the Westernized world.

Autism is a disease of failed love. And love, expressed and denied, may not be only a construct of the mind. Love (both given or withheld) also represents a complex and powerful combination of mental/emotional/physical, (and perhaps other) levels of connection, attention and communication. This connection, empowered by intention, is capable of bringing about profound and measurable changes in the object of that love and in ourselves. Certainly, appropriate love from the therapist, or the intention to heal, constitutes a significant portion of what is vaguely and

imprecisely referred to as the “healing presence” which has been so long recognized in the effective psychotherapist as a necessary component for successful therapy.

**T**his healing presence involves the reception and transmission of unspoken, but potent, signals (including, but not limited to, love) riding on a carrier whose nature we do not know. Neither do we understand the nature of these reciprocal signals themselves although there has been much written about unconscious communication, transference and countertransference, true-self/true-self contact, “vibes”, the corrective emotional experience and a host of other metaphors each of which identifies a portion of the phenomenon. None of these metaphors is truth: each captures a portion of the truth.

In working with autistic youngsters and their families (and with patients in many other diagnostic categories), I have noted that it is the love between the working partners which is curative. The love which I, as the catalyst (or therapist) offer and receive is necessary to liberate that curative love. Bathing each other in a sometimes fiery and fierce, but always productive, empathetic resonance, attachment between the partners is built at such a level of intensity that micro- and macro-repair of every system we know about can take place. Violating dearly held paradigms of damage and repair in a dualistic context, neurological and other deficits regularize, incurable conditions appear cured. The umbra of love which radiates from patient and partner includes those who are nearby. This is a far different love from transference love. It is based in resonance and reality. Perceptual distortions may overlies it, but are quite separate from it. Thus, normal attachment and bonding, therapist intentionality, therapeutic repair and the healing presence may all represent expressions of a similar energetic reality which we, as a scientific community, are now beginning to examine respectfully and rationally. The energetic structure of this love as well as its physical and other properties remains to be elucidated.

Autistic children require us to re-think our understanding of human capacity, of the permanence of neurological and other deficits and of the importance of early experience in health and disorder. Incorporating this information will allow us to act differently both from a preventive and from a reparative perspective. The lesson of those “missing in action” is that the actions necessary to retrieve them must be ours. As parents, as therapists, as researchers, and as members of society we must take steps to end this waste of human lives in the prison of autism.

**CORRESPONDENCE:** Rima Laibow, M.D., Cerridwen, 13 Summit Terrace, Dobbs' Ferry, NY 10522 • Voice: 914-693-882 • FAX: 914-693-8827.

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