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# The use of observation in the psychoanalytic treatment of a 12-year-old boy with Asperger's syndrome[1]

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The author describes some aspects of a once-weekly psychoanalytic psychotherapy of a 12-year-old boy diagnosed with Asperger's syndrome. The patient's emotional and cognitive development had been impaired since early life, possibly due to an internal deficit and to the likelihood of inadequate environmental holding. He was unaware of having difficulties but was underachieving academically, was socially isolated and often visibly unhappy in his life. The patient's denial, splitting, and projection of emotion and insight presented the therapist with the difficult task of how to reach him. In order to communicate with him emotionally, the therapist created a modified technique which reflected the patient's development from part-object to whole-object relationships. This development became apparent in the sessions and was interpreted in the transference relationship. An account of the patient's early years was pieced together from a detailed commentary of what was being observed and intuited by the therapist during the sessions, as well as by an understanding of the countertransference. By the end of two years' treatment, the patient's sensitivity and creativity, which had been buried beneath a self-sufficient, autistic-like encapsulation, finally began to emerge in his communications with his therapist.

Infant Observation… should also increase the understanding of the child's non-verbal behaviour and his play, as well as the behaviour of the child who never speaks or plays **(Bick, 1964)**.

## Introduction

Asperger's syndrome (AS) was defined in 1944 by the German psychiatrist Hans Asperger, one year after Leo Kanner's description of autism. However, it has only recently received wider attention. The main diagnostic systems in use in the USA and Europe, DSM IV (1994) and ICD 10 (1993) respectively, have defined the syndrome as being distinct from autism. However, as the two syndromes share certain features, the distinctions between them are considered by some to be matters of degree (cf. **Trevarthen, 1998**).

The patient I am going to talk about—whom I shall call Johnny—was diagnosed after one year of therapy as suffering from Asperger's syndrome by the consultant child psychiatrist in the clinic where I work, a diagnosis having been requested by the patient's school. The consultant child psychiatrist made her diagnosis by looking at the file notes, talking to the educational psychologist, meeting the mother and seeing the boy herself. She noticed Johnny's difficulty in understanding social cues and the effect

[1] Report of a presentation awarded the 3rd international Frances Tustin Memorial Prize in Los Angeles in 1999.





of his behaviour on others; his inappropriate behaviour in social situations; and his low self-esteem and incapacity to maintain peer relationships. At the beginning of treatment, I considered my patient to have been in a 'post-autistic state'. Meltzer et al. define this state as the outcome of a process of dismantling typical of autism, i.e. a passive process 'akin to allowing a brick wall to fall to pieces by the action of weather, moss, fungi and insects' (**1975**, pp. 12-14). The process occurs by allowing the senses to wander and to attach themselves to the most stimulating, most colourful, warmest, softest objects available at a given moment, and by the suspension of attention. Both Meltzer et al.'s and Tustin's frameworks have been of value in understanding the state of mind of patients like mine, which at the outset of treatment I was only able to intuit. I experimented during the therapy with a particular technique designed to reach and 'to reclaim' the patient **(Alvarez, 1992)**, which I describe here. My patient not only suspended his capacity for attention, but also probably never properly developed this capacity, one which Meltzer et al. saw as the string holding the senses together in a state of consensuality. The patient did not have 'common sense' with regard to conventional seeing or to the ego functions of attention and imagination. I was often led to speculate about the early object relations of this child as well as to try to locate the deficit in his development **(Alvarez, 1992)**, within the schematic knowledge I had of his early infancy and childhood.

Children with AS are commonly described as not being aware of other people's feelings, minds and even of their actual existence (these traits are also used to describe autistic children, although it is clear that the two conditions are distinct and should not, in and of themselves, be confused). They are depicted as being closed up, impenetrable, refractory, almost 'refrigerator' children, just like their mothers were unfortunately considered to be some fifty years ago. I have made extensive use of writings on autism to aid my thinking

around the vulnerability of my AS patient. Reid (2001) and Alvarez **(1999)**, for example, have affirmed that autism is a highly complex disorder for which mothers of autistic children should not be blamed. Child and adult psychotherapists and psychoanalysts (e.g. **Tustin, 1972**; **Meltzer et al., 1975**; **Alvarez, 1992**; **Mitrani, 1992**; **Rhode, 1998**) have noted how mothers of autistic children struggle with a hard 'shell' that surrounds the very being of these children. These authors have depicted the vulnerable and terror-stricken creature who hides inside the shell and who has a 'sixth sense about the state of mind of people who are close to them' **(Tustin, 1994)**, as well as 'a deep sensory openness which is experienced as a bombardment of sensa' (Meltzer et al., **1975**, p. 20). These observations are pertinent to my knowledge and experience of Johnny.

Johnny is a highly sensitive and intelligent boy who, beyond the isolation and the barriers he had erected between himself and the world around him, was capable of intense—albeit rare—outbursts of emotion and intelligent conversation. This was a 'chink in the armour' (Tustin, 1992, personal communication), which also permitted him to experience a flood of tears as early as the first individual assessment session. Such children are viewed as having to deal with an unmitigated sensory input before their neuro-psychological apparatus is equipped to cope with or process strong emotions (**Meltzer et al., 1975**; **Tustin, 1994**). As infants it is likely that they have experienced an assault on their senses from which they have protected themselves by erecting shells, barriers and encapsulations, and these have the effect of cutting them off from direct engagement in human relations.

In the course of therapy with this boy, I was gradually and intermittently allowed to get beyond his protections by verbalising the minutiae of what I could see, sense and




imagine to be the meanings of his behaviour, silences, gaze avoidance, secretive plays and wider behaviour in general. I constructed a number of flexible hypotheses about his possible states of mind and feelings as one does when, after having observed an infant and mother together, one tries to understand patterns of behaviour and likely underlying meanings. I also performed for this patient certain auxiliary ego functions which had been dismantled or had never been there in him.

All analytic work is based on careful observation and awareness of the patient's behaviour, play and associations, and the therapist's or analyst's emotional and mental state while receiving the patient's communication. In Johnny's case, I also found it useful to verbalise my observations and speculations. This way of proceeding resembles more the kind of speculative thinking and reflection which take place in a mother-infant observation seminar, when the observer reports what he/she has observed in detail, rather than the interpretations made to a patient on the basis of the patient's playing or verbal communication. The difference is that an interpretation is made on the basis of observed material, whereas speculative thinking and hypothetical linking is made on the basis of observing something less structured, such as a noise, a sound, a movement or a twitch, to which could be attributed many meanings. This way of employing something akin to an infant-observation technique was necessary, I argue, because Johnny spent long periods in his sessions without talking or playing at all. He rejected interpretations and seemed quite locked inside his body and appeared to me to be lost in his mind. It transpired that a less direct form of communication of the kind I have described had the effect of making a degree of contact with the patient's infantile needs and at the same time lessened his sense of persecution. I give examples of this below. This adaptation of technique, which implies a certain amount of oblique communication with the patient, is something I have found useful in the treatment of children with elective mutism who are unable to play, as well as with some silent adolescents.

## First encounter and early history

My social worker colleague and I first met Johnny in a family session that also involved his mother, his two brothers aged 10 and 14, and a sister aged 8. He was a small, fair-haired boy aged 12 years and 9 months, with no striking features except for a particular walking gait: he tended to swagger from side to side rather than walking forward in an upright manner. In the family session, he giggled a lot with his younger brother and pointed with his finger at his temple, and then at his older brother and his sister, indicating that they were all mad. He interacted with his siblings in a relatively ordinary way and they played with the toys from the box provided. His mother had reluctantly accepted to come with all the children as she wanted only individual treatment for Johnny. Johnny was the second child, conceived just four months after the birth of his oldest brother. He had suffered from projectile vomiting from birth; he was not toilet trained until the age of 5 and all his milestones were delayed. 'All wrong since he was a baby', said his mother, sounding tired and matter of fact. She could not breast feed him, as she was exhausted from the previous child. Johnny was well loved by the extended family, despite being 'wrong, clumsy and awkward', which had earned him the reputation of being: 'Oh poor Johnny!' The family had sought help early on, but was told that nothing could be done for a child like Johnny. They had moved from a distant part of the country, three years before the referral to the clinic, and father and mother had recently separated. Johnny attracted




his teacher's attention as a result of his low self-esteem and a tendency to cry for trivial reasons. Mother was advised to approach a child-guidance clinic, where we met.

## Comment

It seems that a misfit between Johnny and the world had set in apparently from the beginning, when he could not keep his mother's milk inside. He projected it out together with many of his own discomforts and terrors. It is possible that, as a result of this crisis, a fear of death by starvation or by evacuation had been around for both his mother and himself. She had been worn out and depleted by her first child and could not manage Johnny, who appeared to be easily distressed and highly sensitive to stimuli. Meltzer et al. consider that children with autistic-like disorders require something different from ordinary maternal care or a containing, 'good enough' mother (**Bion, 1962**; **Winnicott, 1960**). They seem 'to require the mother to take in, contain and divest of pain the entire child, not merely a part' (Meltzer et al., **1975**, p. 22). Such infants seem to require superhuman mothers who could only exist in an ideal world. Johnny's mother was certainly not ready for the birth of this baby, either psychologically or physically, and in our first session she spoke of the experience of his arrival in a cut-off way, unwilling to re-engage with those early days. Tustin spoke about a 'shock absorber' function of the mother which is usually lacking in the bewildered mothers of such children (1992, personal communication), and seems to have been missing in Johnny's mother. The overflow or spilling over of physical products and psychological tensions, to use Tustin's expression, could be said to be reflected in Johnny's difficulties in being fed and toilet trained.

Johnny's projectile vomiting and lack of sphincter control might be understood, from one point of view, as follows. On the one hand, here was a baby experiencing great difficulty in receiving, processing and using nourishment, as well as in disposing of its unusable residues. On the other hand, here was a depleted mother who seemed to have failed her infant in certain quite fundamental ways.

A fear of death, which I came to think the infant Johnny may have experienced as he evacuated his milk violently, may have turned into a form of nameless dread due to a lack of adequate containment **(Bion, 1962)**. Bion noted how the infant projects his fear of dying into the mother, who under favourable circumstances, digests, transforms and returns the projections to the infant in a more tolerable form. However, when the mother cannot perform this transforming, α-function, the projection is returned to the infant in the form of a 'nameless dread', i.e. charged with the unmodified original fear of dying and in addition with the mother's own anxieties and fears. I was able to see considerable evidence of this later in treatment when Johnny began to drop some of his autistic-like defences.

# The assessment

Johnny had reluctantly accepted to come to see me alone for an assessment for psychotherapy. He would have preferred to come with his siblings, in particular with his older brother, whom he looked up to in awe. He was late for his first session as he had forgotten to get ready, when his mother picked him up from school. He sat silently with a very negative attitude through most of our three assessment sessions. He didn't do anything nor did he let me engage with him. I tried to imagine and speak of his experience of being without his mother and his siblings, how he may have felt and I interpreted his




worries at being alone with me and in a different room. He ignored it all and showed neither interest nor relief at my comments. After a silence, I decided to describe what appeared to me to be his feelings, when he looked sulky, cross, sad and anxious: he said he did not understand me talking about feelings. I began to feel rather desperate about how to connect with him. It was after a certain amount of time had elapsed in the session, and a great number of 'nos' had been uttered, that he finally accepted something I had said but which I then forgot almost immediately. However, he continued to protest that he did not want to be with me and, since instances of contact were so fleeting, I decided to give him permission to leave if he wished to do so. I did not want to increase his pain by attempting in some way to compel him to stay. He did not go. I was struck when, as I later announced that it was time to go, he burst into a sad and depressed cry and refused to go. He pleaded with me to let him do a drawing. His immobility was broken by this experience.

When he returned for his second session he looked more relaxed and told me he felt a little happier. However, a similar to and fro, as in the previous session, soon began to take place. All my comments had to be rejected and denied—this time in tears. Suddenly he began fidgeting on the chair complaining that it was uncomfortable. He scratched his legs, arms and back … then all over his body and it was clearly irritating for him and disturbing for me to watch. It was as if he could not stay inside his skin as this gave him such uncomfortable sensations, which I also began to experience in my skin and body. I spoke of how uncomfortable it was to be there, on that chair, in the room and also in his skin. He looked puzzled. After some time he asked me, over and over again, if he could play with the toys. He never did so, despite the various interpretations I gave him to address his anxieties, his need to have my permission, his desire to be well behaved. I eventually gave him a factual reply that 'Yes', he could play. But still he did not and repeated his question until the end of the session.

In the third session he looked alive, sat in the usual armchair opposite mine and began fiddling with his hands and fingers. He showed some vague interest in my description of his fiddling. 'They are getting together, stroking one another, hiding, coming back, going away … rather like Johnny and myself', I said and he continued this activity looking at his hands as if he was now interested in them and in my comments. This is how he spent most of that session and, when I suggested we meet again after the summer holiday, he declared that he did not intend to come back.

## Comment

The experience of a mother who tries but cannot feed her baby because he evacuates what he is given, was, I thought, being re-enacted in these sessions with me as a mismatch between us occurred. I felt that little or nothing was getting through to Johnny and, when he seemed to be reached fleetingly, my impression was that what counted were the rejections I endured rather than the content of my comments. He projected primitive and uncomfortable sensations into me, which were experienced at a psycho-physical level, and I was occasionally reminded of the work of a Jungian psychotherapist, Mathew **(1998)**. She wrote on a physical experience (which she referred to as 'body countertransference'), which allowed her to link up with deeply unconscious conflicts and anxieties—states of mind that her patient was not ready to express or to project. It seems that those conflicts and anxieties were communicated to the therapist by a flowing into her body, before they could be projected. As they entered the therapist's body, then into her awareness, she began to be able to think about them in her mind. I have experienced a similar type of




'body countertransference' with Johnny, when something that was poorly organised or perhaps comprising some archaic aspects of his personality and mental productions were communicated to me, leaving me confused, unclear, irritable and uncomfortable in my own body. The mechanism by which this communication takes place might be thought of in at least two ways: first, as the mechanism of projective identification where what is projected is less structured and more archaic aspects of the personality are involved. Second, the mechanism may be akin to what Tustin called 'flowing-over-at-oneness' or adhesive identification. She saw this as a process by which the illusion of 'primary union' is maintained: the process occurs earlier than projective identification, implying some sense of bodily separateness between mother and infant (Tustin, **1981**, p. 80). I believe that this was the mechanism through which Johnny was relating to me at those times. The ordinary sequence of projection and introjection appeared to be inhibited or impaired, as though he had not yet gained a proper sense of separateness in certain areas of his personality.

After his treatment had ended, I came across the writings of Corominas on archaic psychopathology and body–ego links in the development of a 5-year-old psychotic girl, who had had cerebral palsy since birth. This girl never spoke but screamed incessantly and benefited from a particular form of containment, which Corominas calls 'sensory-mental-bodily containment'. Her therapist, who was supervised by Corominas, transformed the child's body language into mental, verbal communication in a way similar to the way in which I proceeded with Johnny. She dramatised situations of togetherness and separateness, for example by joining her hands with the child's hands then by moving them apart. Sensations of togetherness and separateness were worked on in an attempt to transform them into emotional and cognitive states and to unblock the child's development (Corominas, **1986**, p. 4).

# Decisions

Johnny's assessment had taken place before the summer and, with hindsight, this was a mistake. To ask him to become involved only to then wait for a long time before returning was too much for a boy with his difficulties. In the assessment he had given me a true picture of how hard treatment would be and I was not at all sure therapy was the best way to help him. Moreover, his mother had been rather derogatory about psychoanalytic psychotherapy but in her desperation acceded to it for her son. I decided to offer Johnny once-a-week psychotherapy following both his mother's insistence and that of my colleague social worker, who, at that time, had carried alive the hope to help him.

The decision to offer once-a-week, rather than more frequent, treatment, was taken for a number of reasons. First, the intense negativity and aversion expressed by Johnny made me question whether he would have given his inner consent even to once-a-week psychotherapy. More intense treatment would have disregarded the patient's conscious message and, in all probability, would not have been sustainable or advisable. Johnny's difficulty in communication and resistance to a closer relationship with me seemed to be entrenched in his personality, rather than being the result of a restricted setting, and I felt that he would have fled had more intense treatment been offered. Practical reasons also militated against considering more intensive treatment. His mother or occasionally his father brought him to his sessions during the first year, but they had to travel a considerable distance and this necessitated making special




work arrangements to manage the continuity and regularity of weekly appointments.

According to my experience of working psychoanalytically with children in similar, very difficult psychological circumstances, it is possible to do helpful work within a proper setting using the transference and countertransference as essential interpretative tools. With such patients each session functions as a mini-week in itself, with a beginning, a middle and an end part to it. I bear in mind and interpret, as appropriate, the different states of mind of the patient, at the reunion after a week's break, in the central part of the session, when some work on defences has been done and even patients who are difficult to reach can become accessible, and at the end of the session, when resistances and closing down can occur.

## The beginning of treatment

After the summer holiday Johnny came with his mother to the clinic without difficulty. During the first two terms, I experienced innumerable rejections from him, my comments being mostly answered with 'No'. He told me that he had no worries or problems: it was other people who had problems. He called me Ms Potty and said that I was mad, not him. He easily gave up talking or made it impossible for me to understand his strong dialect which he usually only spoke at home, as his mother had reported, and during the assessment. Later in treatment, he would only speak standard English and this became a sign for me of greater engagement. In these early sessions my interpretations were mostly rejected or reacted to—even before I could end a sentence. I experienced regular hopelessness and desperation about how to reach him. I decided to resume the approach I had employed in the assessment. As he sat on the armchair opposite mine, hardly doing anything for long periods of time, I described to him what I saw, in a manner akin to being present at a baby observation. I did not address his actions or feelings, such as: 'Johnny is talking, is feeling …', as he rejected this, but I did say: 'Johnny's mouth is moving; Johnny's lips are saying something; Johnny's fingers are hiding …'I spoke to him at what could be thought of as a part-object level by addressing the actions of specific parts of his body. Gradually he became interested in this way of communicating: he touched his lips, looked at his fingers moving and listened to me. Eventually he asked me what I was doing and why I was speaking like that. I replied that I was rather like a mirror reflecting his body. In the following session he brought a mirror. He was annoyed with me and protested: 'See, I can't reflect myself in you, only in the mirror'. However, by the end of that session he looked more alive, and became interested in looking at his eyes in the mirror. In a later session in therapy, he became interested in lights, smells and noises. He closed his eyes as he looked at the sunny window; he twitched his nose and perked up his ears as he heard a noise from outside. I decided at this point to speak of feelings, not only of body parts, in order to see if Johnny might be capable of connecting the two, within our relationship. I said that his eyes were bothered by, and did not like, the sunlight; that his nose was bothered by a funny smell; his ears seemed bothered but also interested in a noise. This seemed to affect him as he looked intently back to the window, twitched his nose or listened to noises. He gradually became more interested and involved in these experiences. He was intrigued by a new perception of his awareness of his senses and of their functions: seeing, smelling and hearing. I think, with hindsight, that I was acting as a kind of 'incubator' in which this 'psychological prem' was beginning to achieve some form




of basic integration which had not been possible in his infancy, to borrow Tustin's imagery (**1981**, p. 195).

## Short-lived play and communication

This section describes a period when Johnny was able to be more verbally communicative, cheerful and playful. This usually occurred after working through the difficult beginnings of sessions, when he would sit opposite me and hide behind his school bag placed on his lap. He would eventually emerge from his distant state and relate to me, often using the 'part-object' technique I have described. In one session, he wanted to make a parachute and asked me if he could cut the cloth that was inside his box of toys. I interpreted his need to have my permission, to be a good boy and that he might be worried about cutting and spoiling the cloth. He ignored my words and insistently repeated the same question. When I included a factual reply that he could cut it, he did not cut it but used it all to make the parachute. The parachute was fragile at first and the doll-man tied to it fell and 'died'. I described this sequence to Johnny as it occurred. He made a stronger parachute that could fly for a little longer. Johnny's repeated questions and refusal to respond had left me feeling exasperated, rejected and puzzled, and I wondered whether this was my countertransference experience of confused, frustrated feelings that he had projected into me. Then, as the parachute got stronger and landed without crashing, and his uncooperative position diminished, I thought that something had percolated through Johnny's mind as he was learning to fly and land his toy relatively harmlessly.

In another session, he set up a theatre play where a family was going to the zoo. Dad was also there and they had a good time. He responded to my interest in his play and to my taking the role of a member of the audience describing what he was portraying. However, when I said this was the family he wished to have, this happy moment was broken. He collapsed into depression, stopped playing, picked bits of dry, hard mud from the soles of his shoes and threw them at me. I said he felt mad at me as perhaps because he thought I had attacked him with bad, mud/pooh-like words, which spoiled his happy family play. Johnny fell into a state of persecution and guilt and implored me not to swear because it was bad. I tried to calm him down, to take in his fears and said it was all right to use the word 'pooh' and nothing would happen but perhaps a thought or voice in him did not allow him to speak like that. He showed no sign of interest in this. However, as the end of that session approached, he repeatedly and anxiously asked me to forgive him. He chastised himself, promising that he would never throw mud at me again and that he had learned his lesson. He acted as if he had committed a crime and was now expecting far worse punishment and retaliation from me. I was struck by this exaggerated reaction, which was not at all proportional to his attack, which, in reality, had been rather mild.

In another session, Johnny played with animal poachers who kidnapped mum and dad wild animals, while cubs and small animals climbed into a plastic container and then went to rescue the kidnapped parents. During the rescue operation, the container nearly fell down but was in turn rescued by other animals. He was playing on his own and was cut off from me. A wave of sleep suddenly clouded my mind and I felt barely able to interpret his anger at feeling robbed of the big animals/parents in his play and of myself at the end of each session. The struggle to climb back to the relationship with the 'parent–therapist' after a gap of six days was

fraught with dangers, such as feelings of




falling apart, but it was hard to know how much of my thinking got through to him, as he appeared to ignore me. However, he eventually started to pack and repack his school bag, looked for his cap frantically then said he might have lost it at school. The session was over, and he left but returned immediately to say 'good bye', which he had forgotten to say. I was surprised, as he had never acknowledged the end of sessions and I wondered whether he was more in touch with a feeling of loss (perhaps linked to the loss of his father, his therapist and his cap). After this session, his mother told me by phone that he went straight to a sweet shop, stole sweets, was caught and was given a warning by the police. It seemed likely that he could only bear the feeling of loss for a very short time. In the following session, he hid from me anxiously, his head inside his school bag; and he said he was dead. He ate sweets and mimicked his hands being stuck with glue and asked for help to unstick them. I said he was eating lots of sweets then playing at being caught, handcuffed and punished, perhaps even to death, and he needed my help. He asked if he could eat the sweets and I did not prohibit this but spoke of his anxieties. Still from behind his school bag, I heard him whisper to himself that he was never again going to eat sweets and was very, very sorry. He got into a delirium-like, muddled state and—still in a whisper not directed at me—pleaded intently for forgiveness for eating sweets and promised to stop. I thought he was transferring his guilt for having stolen sweets from a shop—which he never volunteered to tell me—to a guilt at eating them in the session. In a virtually psychotic way, he was now ridden with persecutory guilt, anxiously wanting to make amends.

## Comment on Johnny's persecuting superego

Johnny's harsh superego, based on the 'law of talion', was beginning to manifest itself. In the session where he portrayed a happy family at the zoo, Johnny threw mud at me in reply to my comment on his wish to have such happy family. I wondered whether he experienced my interpretation as a concrete attack because it reminded him that his real family was not as he wished it to be. Alternatively, he may have felt that I had not recognised a moment when he experienced a good family inside him and in the transference.

The sequence of the play with animal poachers, the stealing of sweets and the session where he repented excessively could be understood as being driven by early persecutory guilt, which could only be assuaged by actual punishment. Freud wrote about delinquent adolescent-like acts, which were also performed by adult patients and which relieved them of oppressive feelings of guilt. The person did not know the origin of such guilt, which was present before such acts, 'and after he had committed a misdeed this oppression was mitigated. His sense of guilt was at least attached to something' (**1915**, pp. **332-3**). I think Johnny was in the grip of a similar sense of guilt and confusion, which in all likelihood had originated in his early infancy.

## Comments on stealing, deprivation and links with separation

Winnicott had a deep interest and understanding of the antisocial tendency and its relation to deprivation and separation. 'A child who steals an object is not looking for *the object stolen but seeks the mother over whom he or she has a right'* (**1956**, p. 125.) It is a loss that occurs: 'at a stage in the child's or infant's emotional development when a mature reaction to loss cannot take place. The immature ego cannot mourn' (p. 132). Winnicott




refers to the time when the libidinal and aggressive drives achieve fusion. Klein (**1935**, **1948**) saw this time when the integration of the 'good' and 'bad' breast or good and bad mother occurs and a whole figure is seen as owning both goodness and badness. The child begins to feel the loss, to be aware of the absence of the maternal object and to tolerate this absence temporarily, if the child has received good enough mothering and has internalised a good object.

Johnny had received some experience of reverie, metabolisation of his projections and understanding during these first two terms of psychotherapy. This good experience may also have reflected some nurturing aspects of his early environment. The episode of stealing sweets had occurred as the Easter holiday approached and Johnny responded as if some good experience had been interrupted and taken away from him. It is a sign of hope, Winnicott wrote, when the child manifests this antisocial tendency as he/she hopes to get back and regain what had been taken away (**1956**, p. 122). In the session in which animal poachers appeared and stole big zoo animals, Johnny may well have felt robbed of his sessions and of his therapist. Just before the Easter holiday he took to hiding in a cupboard, refusing to go at the end of sessions. I felt bad as I wrenched him away from me, trying at the same time to free his octopus-like grip from the furniture he clutched on to. No verbal interpretation about his wishes to stay or his anger at having to go or my badness as I sent him away had any effect on him. Once he went to sleep right at the end of a session saying he 'wanted to sleep for another hour … for a week, ten weeks, a hundred years'. He agreed that he wanted to stay forever. However, by the following week he had—once again—barricaded himself behind his school bag and cut himself off from me. A strong attachment to me and to the sessions went together with an equally strong rejection and apparent disinterest as a defence against his feelings about gaps. It was like an unpredictable relational seesaw, which later on would become rather more predictable. On our return after Easter, a powerful

resistance was to burst out suddenly and violently.

## The Easter break: A new technique is required

When Johnny came back after two weeks, he had greatly deteriorated. He took to coming to his sessions very late and often sat in the waiting room for the remaining time, refusing to leave it. When he eventually came to the therapy room he fell asleep behind his school bag and slept for whole sessions, despite my waking him up and interpreting about the holiday break, his need to control and his projections into me, and he ignored it all. When he did not sleep, he was angry and provocative, argued and battled with me over anything or kicked, shouted and threatened to 'do me for assault' if I held out my hands to protect myself. Alternatively, he mocked me and spoke contemptuously, parroting my voice. In the countertransference, I experienced anger—an anger that I felt sure reflected his own and which he refused to tolerate whenever I tried to address his feelings. He continued feeling highly persecuted, until he eventually clammed up completely.

My technique of reaching him was no longer successful, during this phase, and I had to find new ways of working with him. Interpretations of his unconscious conflicts, anxieties and defences, which would have reached a more neurotic patient and which from time to time had touched him, now failed, perhaps because of their being too directly focused on his heightened affective states and therefore too persecutory for him. There was a definite limit to how much Johnny could bear being reached, and this was reflected in the fact that a lot of psychoanalytic processing was taking place at this time in my




own mind, rather than his, since he spent long periods hiding behind his school bag, saying little, doing little and rarely responding to my interpretations with words or clear behaviour. What was always encouraging and interesting about working with Johnny, however, was his capacity to evoke and inspire in me new ideas and imaginative thinking which allowed me to find ways to relate to him, his barriers and defences notwithstanding. I thought that this was a sign that he was not in an autistic, deadening state that kills hope and enterprise in the therapist. I found myself feeling more creative and producing new ideas to a degree that surprised me. It was as though his creativity flowed into me through a type of unconscious mechanism, which I have tried to clarify earlier in this paper. I believe that what flowed into me, and left me rather unaware that it was coming from Johnny, was not a clear and specific aspect of his personality but, in his case, a preconception of a form of liveliness or creativity, as Rustin (2000) commented to me.

My technique now consisted in initially developing a dialogue, first with an imaginary friend, later with Johnny himself. I described to this friend what I could see, imagine or hear Johnny was doing behind his school bag and the 'friend' replied to me. 'Listen to that noise … is it the wind?' 'No, it's a bird outside.' 'No, it's a person sleeping.' 'It's a child, a boy.' 'Yes, he must be fed up and cross.' 'I think it's Johnny, he's fed up!' 'He didn't want to come to his session today!' These dialogues began to arouse Johnny's curiosity, again I think because he experienced them as less persecuting. He pushed his bag aside, looked straight into my eyes—which was rare—and asked to whom I was talking. I explained that I was talking to an imaginary friend and—in case he did not understand the concept of imaginary friend—I added that it was like two friends talking to each other or a mother and a father talking about their child. He was clearly touched by this type of communication and seemed to understand the concept of imaginary friend, and he became involved again with me through playing and talking, even if only for the last part of his sessions.

Occasionally, I spoke as if I were Johnny thinking. 'She's a bore! She wants to know what I'm doing. She's nosy; she shouldn't say that she can hear me eating sweets. I feel bad if she says I'm eating sweets.' Once he responded: 'No, I'm not reading!' 'Yes, I feel bad if I eat sweets.' At other times I gently mirrored his noises, for example, breathing, chewing, gulping, yawning, turning pages, writing, which he produced hidden away or tucked inside the protective shell of his jacket. This also caught his attention and encouraged him to interact with me, even if usually only through disagreement and protest.

## Comment

Sweets seemed to stand for a prototype for Johnny of some desired, oral gratification that he felt he was not allowed to have or receive generously. They seemed to represent a 'good and sweet breast', which he seemed to have had briefly but lost and needed to steal back in a secretive way, hence feeling guilty and persecuted. Rhode **(1998)** writes of the baby's understanding of 'the mother's emotional unavailability—her mental *pre*occupation—as being the consequence of her physical *occupation* by someone else' (p. 473 in the German version). The presence of the 'other' had been a constant in Johnny's infancy; a presence which had deprived him of his mother's full attention.

Johnny had fluctuated between sessions when he needed autistic-like defences **(Tustin, 1986)** to shut out the persecuting, intruding and terrifying world of others, and sessions when he talked, played and appeared more at ease with himself, with me and the world at large.




The adaptations of technique paralleled roughly Johnny's stages of emotional development: from a 'part-object' form of relating,

when I addressed parts of his body and their associated meaning, to a whole-object relation when I spoke of Johnny himself or myself doing something or having feelings. Then a third person was introduced—an imaginary friend or father figure with whom I had a dialogue, about Johnny. This could be seen as a reference to a 'combined object' **(Klein, 1952)**, which Johnny was gradually able to accept and be curious about.

## The last phase of therapy

In the fifth term of therapy—from Christmas to Easter—I saw little of Johnny. He missed sessions, came late or was unreachable and slept. His ups and downs continued and I never felt we reached a stable plateau. Johnny was occasionally suspended from school; these disciplinary actions were, I suspect, in part because the school authorities had not properly taken in that he was a boy with special needs. He was also found by the police wandering on his way to the session, lost both in the streets and inside himself. Anger, defiance, stubbornness, rebellion, provocation, were now the principal features of his sessions but Johnny seemed unable to take on board such states of mind and feelings. Plans for him to go to a residential school for children with Asperger's Syndrome were being made and he seemed to look forward to that, despite his anxieties and uncertainty.

## Looking: A source of anxiety

In the ups and downs of his moods, an interesting theme had emerged and, in the last few months of treatment, became more explicit. Johnny had told me, at a moment of sincere contact with me, that he did not like looking at people's eyes. I tried to explore if he was scared, angry or fed up, if he looked at people's eyes, but he did not know. In my attempt to understand him, I wondered aloud whether perhaps, as a small boy, he had looked at his mother's face and eyes and sensed that she was tired and busy, and felt as if she could not see him. Perhaps he wouldn't have liked that and now he preferred not to look at people's eyes. I often speculated aloud about his early days in sessions, as a means of composing a possible narrative of his early life, which he seemed to lack in the way children subject to developmental delays exhibit. He would listen silently and noticeably did not protest, and I felt he was somewhat interested.

In a session before a long break, Johnny looked fed up and harassed as he walked from the waiting room along the corridor. In the room he slumped, as usual, into the armchair and hid behind his school bag. There was a long silence: I said that perhaps he was hiding his feeling of being fed up. 'No, I'm not fed up', he replied. After a long silent spell he peeped from behind his school bag and asked me, 'Can you see my eyes?' 'Can you see my face?' 'Can you see me?' He was still hiding but was able to see me between the straps of his bag. I said, 'You can see me and are not sure if I, too, can see you'. After a silence and more of the same peeping game, I added, 'You want to see me without being seen'. After another long silence and immobility on his part, I heard him saying, 'Going to sleep'.

*A: You seem tired.*

*P: No. What will you do if I go to sleep?*





*A: [I decided to reply factually to avoid another familiar impasse.] I'll wake you up.*

*P: I'm not going to sleep.*

However, within minutes, he fell asleep behind his the bag. I woke him up by calling his name. I allowed some silence to elapse before I told him that I had brought a note with the dates of the coming holiday.

*P [From behind his bag]: I cannot hear and see … I don't hear with my nose, mouth, eyes.*

*A: I'll tell you the dates and I will show you the paper with the dates written on it.*

*P [In an annoyed tone]: I can't talk and hear at the same time. [Pause.] I can't hear and see. I can't see and talk.*

I said it was hard to talk about holidays. He moved his bag aside, stretched one arm towards me and reached for the note with the date. He looked at it and said he was not coming next week or in three weeks' time. He was going on a school trip and … he did not finish his sentence. I said that he was giving me his holiday dates and this was making him feel better about mine. Then he blew air into a pen, dropped coins, tore bits of paper off the holiday note and let them fall from his hands. He conveyed to me a feeling of being in pieces and dropped by me. I said this to him and linked it with not seeing each other next week and also later on. It was the end of the session and he did not come during those weeks for the reason he had given.

### Comment

We can see from the above exchange the impact on him of knowing that he would miss sessions and also of the announcement of a long holiday. The peek-a-boo game he played was, I think, his way of attempting to master the difficult experience of separation from me. In this game, which is typical of a much younger child, he was trying to take control of seeing and looking at the other person, thus doing something we knew he had not liked before. Moreover, I found particularly interesting his graphic awareness that he could not co-ordinate various sense organs in a harmonious way, rather like infants who do not yet have the capacity to co-ordinate movements and sensory activities.

For Bion, a ‘common sense’ is an essential mental act ‘which apprehends objects in their multifaceted aspects as opposed to neuro-physiological events’ (Meltzer et al., **1975**, p. 13). However, for a common sense to develop in Bion's terms, the nursing infant has to have an experience where the senses come together in a gratifying and containing feeding situation. Andersen **(1992)** wrote about this in her intensive therapy with a 3-year-old boy with autistic features. She referred to a good feeding situation, where the baby is held by the nipple in the mouth, by the flow of milk in the stomach, by the eye contact with the mother and by the physical holding of the baby in the mother's lap. These sensory experiences, simultaneously co-ordinated, develop the cohesion of a psychological common sense and a sense of oneself as a recipient of those profound physical and psychological experiences. For Bion, common sense implies that the senses are in harmony and support each other, as we can imagine they are in the good experience of the baby at the breast (**1992**, p. 10).

Johnny did not seem to have achieved a harmonious co-ordination of senses as a small child and now he could not perform adequately two activities at the same time, such as hearing and seeing or talking and hearing, without much anxiety.




## Loving looks

In another session, he said again that he did not like eye contact and asked me if I did. ‘Yes, it's nice’, I answered. ‘Why don't you marry “eye to eye”?’ he asked. I suggested that he was scared of eye contact because it was too nice and perhaps exciting. He then initiated guessing games, quizzes and puzzles with me and looked straight into my eyes. When I guessed names or numbers correctly, he would look up at me at times, from his sitting position on the floor, with a radiant look, in awe, reminiscent of a blissful infant at the breast looking up at mother. It felt like a moving and aesthetic experience for both of us. I was reminded of Meltzer and Harris's **(1988)** thought on the aesthetic conflict when Johnny looked embarrassed, blushed and told me not to stare at him. This loving gaze could be too much for him. Perhaps his looming adolescent sexual feelings may also have been emerging at that time. His loving feelings towards his object, i.e. his therapist in the transference, became more explicit when he proposed that we read the story *of Romeo and Juliet* from a book he had brought. I chose the part of Juliet and he chose Romeo. Having tolerated, named and helped to transform a good deal of his rage, aggression and truculence towards me in an earlier phase of therapy, Johnny now seemed able to access more of his loving feelings towards the object.

## A boy with a heart

Johnny was to move to his new boarding school after half-term. He had visited the school and felt at home there. This he told me in the session following the visit and which was to be our last session. He had brought a plastic cube with small metal balls inside, which had to be fitted into tiny holes by gently changing the orientation of the cube. He managed this quite skilfully and I spoke of this ability to make them fit, of the home that he felt he had now found in the new school and also in his sessions with me. He nodded. He then read two poems that he had written at home: he wanted me to have a copy of them. The first one was about a boy, himself, who was apparently not brainy or bright but who had a heart and feelings. The second poem was about nature, the dawning day, the rising sun, and then the rain. I was moved by the depth and the clarity of his feelings and that he had been able to access and express these in poems. I said he was telling me a great deal, not least that he had discovered a capacity to have a heart and feelings. He looked at me with a transfixed stare and said—holding his breath and emotions—that he loved me and would miss me. Then he hid his face as he blushed with what seemed to be a mixture of pleasure and embarrassment. He took the poems with him and this was the last time I saw him.

## Conclusion

Johnny, aged 12, was taken to see a child psychotherapist when his feelings of being at odds with himself and the world had virtually stopped him from learning and socialising. He was extremely persecuted, isolated and withdrawn behind a protective shell, especially when he was outside home. In therapy, he was difficult to reach, felt easily intruded upon and seemed empty of thoughts or memories. However, I felt that he was able to let some of his internal world flow into me as I found myself inspired, enriched by his ideas and impressed by his intuitive understanding. He slowly opened up through a




modified technique that I gradually evolved through my work with him. He went through a phase of anger, aggression and truculence that were, on the whole, out of character with his hypersensitive, meek disposition. Their understanding and containment paved the way to eventually meet a ‘boy with a heart’. The end of his therapy was precipitated by admission to a special boarding school for children and adolescents with AS. This final stage ushered in an attachment to the therapist that had been anticipated in the past by Johnny's reluctance to leave at the end of sessions. Such attachment was a mixture of tender, loving feelings and embarrassing erotic responses.

Children with AS seem to me to struggle with a sense of there being a void at the depth of their existence; their loving, hopeful

and lively feelings are consequently greatly impaired. The variation on an infant-observation technique used to reach and to communicate with Johnny helped him to articulate some sense of himself as a boy who could experience loving feelings. This was an achievement for a child who had been dominated by hatred, negativity and despair that had undermined any therapeutic effort. The sudden appearance of positive and loving feelings, at a time when we were due to stop therapy, left me somewhat perplexed. When I had previously kept some distance from Johnny and engaged in dialogues with imaginary people, he had been able to reach out for the object and to be curious about it. Rhode **(1999)** has suggested that this was a safe distance which may have reduced his fear of being trapped and sucked in, as had occurred in the first assessment sessions, when I gave him permission to leave. Only then could he stay. It is quite possible that his capacity for loving feelings re-emerged because of the imminent end again providing a distance and a safe space to allow himself to feel.




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