THE AUTISTIC MOMENT IN PSYCHOTHERAPY*

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ABSTRACT: This is a report on the author's experience in treating four autistic children and their families. The importance of making available the therapist's own autism is stressed. The difficulty in doing this and reverting defensively to an administrative approach is described. A previous paper discussed the "corrective autistic experience" with a focus on the autistic person. This follow-up describes the "autistic moment" which is a relational experience between the therapist and both the autistic person and the autistic family. The family needs to have an experience of its own autism as a continuum of normal before it can relate to an autistic child. To the extent that the therapist can bring his own autism into the therapy can the family experience its own. The patients are the person, the relationships, the family, and the therapist.

Remaining therapeutic in the face of administrative pressure is a difficult task. It is always difficult with families where a child has infantile autism. Autistic children do not talk to the therapist very...
much, do not provide much in the way of symbolic play to interpret, and provide little to connect to in a relational sense. Progress is always slow and difficult to measure, and the goals of the psychotherapy somewhat vague and open-ended. Furthermore, it is sometimes seen as anti-cultural to attempt to be therapeutic with an autistic child, apparently in part a reaction formation to the blaming of “refrigerator mothers” for the autism in a previous psychiatric generation. An equally valid hypothesis for the existence of the “refrigerator mother” is the induction of such a state by the autistic child (Anderson, 1979), or perhaps the result of an obligation to a certain kind of marriage or family. The regression necessary and inherent in becoming a mother, along with the various identifications and counter-indentifications with an autistic child, provide ample opportunity for a mother to become relationally autistic. Inevitably, success in treating an autistic child is met with a redefinition of the original diagnosis. The Tinbergen’s (1972) assert that many children are temporarily autistic, but are rescued by good mothering, social therapy, or good psychotherapy before the condition becomes irreversible. Certainly, the premise of a previous paper (Kramer, Anderson, & Westman, 1984), to which this report is in part a followup, was that autism is on a continuum which includes normality.

As stated above, there is tremendous pressure to become administrative when working with autistic children. This pressure is both internal and external. On the one hand, the slow progress, the lack of relational gratification for the therapist, and the uncertain prognosis often lead the therapist to withdraw emotionally from the therapy (i.e., to become therapeutically cautious). On the other hand, the obvious needs of these children and their families provide many worthwhile reasons for someone to be administrative. School programs need to be arranged and monitored. The family often needs an advocate, and one with an MD degree can be very helpful. Learning skills such as behavior modification can be important to the parents of an autistic child. Anti-psychotic medications are often recommended by child psychiatrists (Cohen, Campbell, Posner, Small, Triebel, & Anderson, 1980). The psychiatrist can become involved in helping the family to organize a more structured environment, and sometimes assist in arranging residential treatment, or ultimately, placement.

As can be seen from the above, there is a lot in which the child psychiatrist can involve himself to provide both for the obvious needs of the autistic child and his family, and also to substitute for the therapeutic emptiness inherent in such an effort. However, this attention to the obvious may be a subtle form of countertransference. Searles