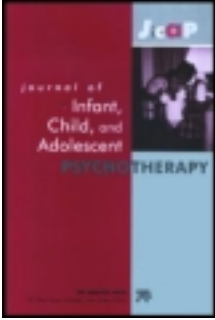


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Miriam Voran

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The Protest of a 6-Month-Old Girl: Is This a Prodrome of Autism?

Miriam Voran

This article describes the infant-parent psychotherapy of a 6-month-old girl. This anxious, almost inconsolable, baby girl used withdrawal, dissociation, self-harm, auto-stimulation, and passive to active reversal, especially with her mother. Both her parent's feared she was autistic. Indeed, the baby, as if protesting what she felt to be a painful interaction with her mother, developed defenses that, to the author, looked autistic. During five months of infant-parent psychotherapy, her parents learned to contemplate her emotional life and helped her become a normally developing toddler. This case raises the question: If the child's defenses had become entrenched, would she have eventually been diagnosed with an autism spectrum disorder?

This article describes the infant-parent psychotherapy of a 6-month-old girl. The treatment was guided by concepts touching deep levels of the mind: Bion's concept of containment and what was formerly called autism by Tustin (1981). The kind and quality of the child's symptoms reminded the therapist of symptoms described by Tustin—symptoms that Tustin believed evaded the pain of a premature rupture of psychological containment. The therapist made contact with each family member as fully as possible, sometimes speaking to the baby herself to reach the deeper layers of the parents' minds. In this way, she modeled a containing, reflective function, with which the parents and even the child began to identify. The family began to develop its own reflective function, all members becoming more attuned to each others' emotional lives. The little girl responded rapidly to treatment, and her bizarre defenses evolved into playful, productive interactions with her parents. The course of therapy left the therapist wondering about the girl's developmental future, had her parents not sought help. What was I seeing? Was this an autism spectrum disorder *in statu nascendi*? I'll explore this important diagnostic question by examining connections between contemporary scientific research and Tustin's theory of autism.

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Miriam Voran, Ph.D., has a psychoanalytic practice in West Lebanon, New Hampshire and Montpelier, Vermont, and is an Adjunct Assistant Professor at the Geisel School of Medicine at Dartmouth.

Correspondence should be addressed to Miriam Voran, 79 E. Wilder Road, West Lebanon, NH 03784. E-mail: Miriam.j.voran@dartmouth.edu

A CRY FOR HELP

Mrs. B, referred by the pediatrician, phoned me after her daughter Jane's six-month check-up. When I reached her that evening, she poured out her concerns: Her daughter cried ceaselessly, refused to look at her parents, threw "hissy fits" at the smallest things, and, when in their arms, arched her back as if trying to hurl herself to the floor. "Something was terribly wrong." The pediatrician prescribed an antacid, and when it did not work, prescribed a second, ineffective medication. Mrs. B, exhausted by Jane's relentless crying, was despairing, believing she would never find relief for her baby and the household. She was willing to try psychotherapy, as a last resort.

Two days later, Jane and her parents, trim people in their early 40s, arrived at my office. Mr. B carried Jane, a sober baby with broad cheeks and blue eyes, and paused just inside the door, presenting his daughter to me. Mrs. B followed, with a bulging, well-stocked diaper bag. Jane stared blankly through me for several seconds, looked down, stared at me again, looked down, backward, and around the room. I greeted her, the family settled into the couch and Mr. B began by telling me that Jane angered easily and was inconsolable, or she was bored and seldom able to be amused. For a month, she had wanted to walk and was happiest when her parents held her hands as she marched about the room. I thought this precocious for a 6-month-old. Mrs. B said that Jane's only comfort was her mother's breast, though not always, because sometimes Jane screamed unpredictably in the midst of nursing. The baby had no special smile for Mrs. B, even after day-long separations. Worse still, in the last several weeks, their daughter, when upset or excited, had started to hit her forehead with toys, leaving bruises. More and more, Jane avoided them.

Mr. B, also discouraged, confessed that *he* often wanted nothing to do with *Jane*. He and his wife, he said, argued loudly about their screaming baby and then felt guilty, knowing that their yelling had only upset her more. Mrs. B sat quietly during Mr. B's confessional and when asked how she felt about Jane, blushed, saying she too often hated their long-awaited daughter.

As the parents talked, Jane looked at me and her parents. She startled when Mr. B spoke loudly and looked momentarily, perhaps searchingly, into his eyes. While unloading their concerns, the Bs tried to play with Jane, calling her name, showing her a rattle, or jostling her. Jane looked away; the parents persisted, failed, and finally grew exasperated. At one point, Jane, sitting on her mother's lap, flopped backwards and then righted herself, face bright red. Mrs. B said Jane had started this breath-holding in the last month. Later, Jane began to fuss and Mrs. B spread a baby blanket and lay Jane on her back. Jane extended her legs and locked her knees, then began to rhythmically rotate her limbs like a helicopter starting its propeller, preparing to fly. This had also started in the last month.

One hour into the consult, Mr. B noted that Jane was not crying; he said they would be relieved if Jane continued this at home. Everyone in the family was relieved, I said, to have someone think with them about their struggles with Jane, and the parents agreed. We planned several more assessment sessions and, knowing the parents would welcome feedback and suggestions for things they could do at home, I gave my initial impressions: Jane was interested in her parents, but her hypersensitivity frustrated their efforts to comfort or console her. For self-soothing, she withdrew into bodily sensations; this was disturbing. Therefore, I suggested, we should help Jane experience more pleasure with people. Perhaps they might start that project by imitating her facial expressions and watching her response.

BABY REACHABLE OR UNREACHABLE?

Five days later, Mrs. B arrived with Jane; Mr. B had traveled to a conference. Jane greeted me with a stare and, in gratifying contrast to our first encounter, broke into a wide smile, then looked down shyly. Mrs. B, now more relaxed, reported that Jane had played with them some mornings; they were engaging her 20 percent of the time. Mrs. B eagerly showed me their face-to-face play. I noted, privately, that Jane often stared blankly at her mother or turned away, whereas she eagerly searched for my eyes. We discussed Mrs. B's desperate need to reach Jane and the vicious cycle this created: mother would inadvertently overstimulate Jane, Jane would withdraw, mother would feel discouraged, and, in turn, try even harder, further repelling Jane. Now, here in the office, Mrs. B tried another strategy. With Jane lying on her back, Mrs. B leaned over and smiled. This heart-breaking sequence followed: Jane looked into her mother's eyes, then froze, stiffened her body, and began rhythmically moving her legs, looking vacuous. Mrs. B broke into tears, lamenting that, ever since Jane's birth, her baby wouldn't attach to her. She had always felt something was broken in her daughter and, after watching a television show on autism, feared Jane was autistic. Privately, I thought Jane was reacting to some disorganizing anxiety in her relationship with her mother, an anxiety that Jane, perhaps because of her particular sensitivities, experienced as traumatic. To Mrs. B, I said that Jane's behavior concerned me too and, staying close to her concerns, added that I believed autism to be a disorder of development and that, therefore, babies can and do respond to treatment if started early. Jane, I said, was lucky that her parents were seeking help. We all, I continued, needed to think about the meaning of her distress signals. As we prepared to end the session, Mrs. B apologized for her tears. I expressed puzzlement and noted that this reserve would be worth understanding. I also observed that Jane had calmed twice today in her mother's arms. Mrs. B, with excitement and pleasure, said that this had never happened at home.

In these first meetings, Jane's bizarre behaviors after eye contact with her mother suggested to me that she had experienced something seriously disorganizing in their relations. Understanding this difficulty guided my inquiry. What had transpired between Jane and her mother? What sensitivities or information-processing difficulties in Jane might have predisposed her to extreme reactions and unpredictable behavior? I was also curious about Mrs. B's mind—what did Jane's behavior mean to her, what reactions did they engender in her, and how did she feel as a parent? Likewise, how did Mr. B experience his daughter and himself as a parent, and how did the marital interactions influence the family atmosphere? Jane's adaptation to her situation—looking away, withdrawing, freezing, self-inducing pleasure or pain—were they to become entrenched, could cut her off from essential human interactions and distort her development. The malleability of these defenses was the second concern and focus of my work.

When Mr. B rejoined the family next session, I recommended infant-parent psychotherapy to help Jane enjoy her parents and help the parents better understand their difficulties with her. Mr. B elaborated on his frustration with Jane's fussiness and conceded that he didn't fully understand the depth of Mrs. B's pain. Mrs. B agreed, saying that, although they talked constantly about what to do with Jane, she had not expressed her despair. They wanted to meet twice weekly and so we began.

THE FAMILY'S STORY

The couple, wanting life to go right, had waited to have a child until they had established their legal careers and their household. They then endured two years of infertility and had just decided to seek treatment when Jane was conceived. The pregnancy was unremarkable, except for Mrs. B's worries about the fetus. Labor began two weeks early, and Jane, stuck in the birth canal for 41 hours, was finally delivered by emergency C-section. Confronted with her infant's early aversion to her, Mrs. B wondered why she, of all people, had a daughter who would not attach. She wondered if the C-section and a subsequent hour, during which Jane had been withheld from her, had contributed to the bonding difficulties. However, C-sections, she reasoned, were common, but babies like Jane were not.

Mrs. B joked that her law practice had been her "first baby." Even as the parents were returning from the hospital with newborn Jane, Mrs. B checked in at her office, as she had not completed all her work before Jane's early arrival. The parents remembered those first weeks as hectic, mother being impatient while Jane nursed, mother pressured and tense, checking her watch, almost frantic to return to work. Then came the planned maternity leave and a trip, some "away-time" that the couple remembered fondly. It was when they returned home, it seemed, that Jane's troubles started. They then retracted this theory, realizing that Jane had always overreacted to stimuli, was quick to startle, and had never slept well.

It was curious that, throughout the therapy, the parents, especially Mrs. B, were reluctant to discuss their lives before Jane. Mr. B reported that his parents divorced when he was young and that he had been raised primarily by his father and stepmother. Mrs. B, even more guarded, only revealed that she had been close to her mother and that when she was seven, after the birth of her brother, her parents divorced. She said her father had disappointed her.

ATTACHMENT BLOOMS, BUT FEARS PERSIST

During sessions, the parents brought news about Jane and sought advice. I facilitated their interactions, played with Jane myself, suggested how they might reach her and encouraged them to try. Above all, I contained their disappointment when they failed. Jane did well during sessions—waking up and playing quietly with her toys, leaning into her mother's body, sustaining interactions with mother. Mrs. B noticed that Jane had become more social, now smiling and looking at clients and co-workers at mother's office, but she still wanted Jane to give and receive love. Jane surprised her parents when she recognized her car seat and wanted to crawl in; Mrs. B protested that Jane had a special smile for the car seat, and not for her. I helped Mrs. B identify the frustrating gap between the baby she had expected and the one she actually had; and I helped her acknowledge, to herself, the pain of their alienation. As Mrs. B became more aware of her sadness, we could discuss how Jane also felt hurt by the gap between them. As Mrs. B found ways to let Jane know she recognized Jane's sadness, she was showing Jane that she wasn't giving up on reaching her, no matter how painful the gaps or how toilsome the process of closing them.

In the second month of treatment, the parents reported new attachment behaviors—Jane cried when a relative arrived and calmed when snuggling into father. At a birthday party, Jane calmed when Mrs. B held her, and she was now showing stranger anxiety. In session, Jane gazed and

smiled at her mother for a long time, then burrowed her forehead into mother's chest. Both parents were delighted and had never seen Jane have such fun with her mother.

Five weeks into treatment, the Bs, anticipating my two-week vacation, worried they would feel helpless in the breach. Mother planned to keep a daily log. She also asked if Jane should see a sensory integration therapist who specialized in working with autistic children. Mr. B, however, detecting the paradox, reminded Mrs. B of how much had already changed and asked why she would want to interrupt something that was working so well. Privately, I wondered if this impulsive temptation foreshadowed a premature termination, a rupture in our link.

The Bs returned from the break brimming with news—Jane had waved excitedly when her mother came home from work; she had looked tenderly at her mother's breast while nursing, then fondly into her eyes. Yet, Jane was also zoning out more, gazing at the fan or locking her eyes on bathwater swirling down the drain. Two weeks later, Jane started pulling her hair when frustrated. For the next month, elated by good signs and deflated by bad, the Bs teetered between hope and panic.

DISSOCIATIONS

Early in treatment, Mr. B had noted that Jane became mesmerized by the white snow on TV; together we had seen her stare at plant leaves flickering in the air conditioner breeze. Two weeks after our break, Jane had stared at a moving light at a department store. The next day, when supporting herself on hands and knees, Jane “froze” for 15 seconds. Mrs. B tearfully worried that her daughter had autism. In reassurance, I shared feedback from my consultant who had just reviewed a videotape of a session (this videotaping occurred only once). The consultant, who had seen many troubled infants, noted the tension and fear in everyone around Jane but also saw Jane as reachable. As I said this, Jane started to fuss, but her mother calmed her with a pacifier and gentle backrub. Jane's soothing, said the parents, was encouraging. Privately, I thought they must be relieved to have a fourth mind thinking about Jane.

SCREECHING AS A NEW MODE OF COMMUNICATION

At week 11, I visited the family's home, a clean, sparsely decorated farmhouse, with tall windows through which Jane loved to watch the trees and birds. In contrast to this serene landscape, an acoustic pandemonium of music and multiple TV channels bombarded the inhabitants and I wondered if the din interfered with Jane's attention to her parents' words, for she rarely babbled or imitated their sounds. The parents agreed to reduce the noise, but at our next appointment Mrs. B explained that the silence made her want to scream. In fact, Jane herself had started to screech with spine-chilling shrieks that made mother want to screech back. We explored what preceded Jane's screeches—mother had made a phone call, Jane was placed in her car seat, or Jane was using her walker. The parents insisted that her screeching was random, and Mrs. B dismissed the idea that Jane might be trying to regain her attention. During the session, Jane screeched when Mr. B hid a toy, and we agreed that she had gotten excited and frustrated. Together, we

discussed the need to set firm limits around the screeching and to teach Jane other ways to communicate.

As we talked, Jane cried when mother gave her the sippy cup instead of father's coffee that she wanted. Jane watched intently as mother gave her doll "Darcy" a drink from the sippy cup, and then took her own drink. Mrs. B explained that, following my suggestion, they took Darcy everywhere with Jane. At night Jane played with Darcy in her crib and cried when Darcy couldn't join her in the tub. The Bs were anxious about tomorrow's long-awaited evaluation with a developmental pediatrician and hoped the doctor would witness Jane's zoning out and screaming. The parents now recognized three kinds of screams—happy, mad (because she wanted their attention), and the "out-of-the-blue" kind. We laughed about how far they had come from their initial concern that Jane wanted nothing to do with them. Mrs. B also noted that Jane no longer startled as much. We were close to the session's end, which Mr. B said Jane must have known because she returned her cereal to the diaper bag. I heard my own words in this comment and, to myself, noted also how far the parents had come in understanding Jane's mental life.

AUTISM DISMISSED

After three months of treatment, the developmental pediatrician declared Jane to be thriving, with no signs of autism. The parents were relieved, but also felt their concerns had been disregarded and that their efforts to help Jane had gone unrecognized. In sessions, I helped the parents integrate this good news with their earlier fears, and to appreciate the wholesome effects of having courageously explored feelings that many parents might avoid. I thought to myself that the doctor's view of autism as an innate, intractable neurological disorder had contributed to the parents' feeling dismissed. (In fact, the doctor later told me that Jane must have had an attachment problem with her depressed mother, a condition she considered unrelated to autism.) The parents explained that they needed to justify to themselves and to others the path of therapy they had taken. Others had thought it unnecessary, but they believed that, without therapy, Jane would still be in trouble.

As I asked more about their need to defend their therapy, Jane fussed and looked toward the door. Mr. B thought Jane wanted to leave and said she had never done this in session before. Jane sensed her parents' tension, I said, explaining to Jane that her parents had been worried about her and had worked hard to help her, yet this topic was difficult to discuss. The parents ignored me, and I, recognizing that this line of exploration was off limits, returned to mother's earlier concern that Jane preferred father to her. Was it difficult for mother to believe, I wondered, that she had created a strong beautiful daughter who could love her? Father thought it was just the opposite; that the mother wanted a daughter who would love her and was frustrated because this had not occurred. Mother, who had been ignoring me as she played with Jane, responded curtly that she did not want to talk about herself or the past, slamming that door shut. Father said he was still thinking about how strong Jane was to keep protesting and get them help. I reinforced his contribution, elaborating on the ways in which Jane was not the baby mother had imagined, but that Jane had kept protesting for a real relationship, based on who she actually was.

NEGOTIATING SEPARATIONS

Now reassured by the pediatrician, who had ruled out autism, and by their own observations of Jane's blossoming social interest, the parents could confront the ordinary issue of nighttime separations. Mr. B wanted to help Jane learn to sleep in her own room (she continued to sleep in a crib in the parents' room), but Mrs. B felt he was rushing the move. After we made a plan, father worried that mother would resent him for wanting to move Jane's crib. We discussed how they as a couple were also learning to handle anger and the separation implicit in their disagreement.

Jane had also started to say no when being put to bed or moved away from the window. Mr. B recognized that Jane was voicing her opinion and Mrs. B agreed. As we discussed the progress with nighttime separations and the onset of Jane's talking, Mrs. B was happier and more relaxed than I had ever seen her, lying on the floor and smiling as she watched Jane play with the cloth birds and bird house.

We also discussed the parents' new professional responsibilities, planned before Jane's birth, that were about to demand more of their time. This poignant situation, in which Jane was finally getting to know and enjoy her mother, but about to lose several hours a day with her, I described to the family. Mother said that my comment left her feeling guilty. How important, I told her, that she recognized her guilt. She could have avoided that sensation as well as Jane's reactions, and that would have alienated her from her daughter.

One day, Mr. B asked if it was ok that Jane loved to carry electronic gadgets and demonstrated her gaze locked on the screen of a music-making MP3 player. His question to me, I said, signaled his own hesitation about giving Jane these gadgets. Jane, I reminded the parents, was falling in love with them. Why distract her with machines?

FLIGHT FROM INTIMACY

After four months of twice-weekly psychotherapy, the parents, more confident about Jane's mental health and more involved with their growing careers, wrestled with the need for treatment. They soon discovered that they had time for only one session per week, and if I would not agree to this they would need to stop completely. Although I recommended keeping the twice-weekly schedule, I agreed to weekly meetings, with the proviso that we protect the time as a cell-phone-free island of calm for the family, as calls had started to intrude into the sessions.

The B's stopped taking calls during sessions, but they became more remote and would only discuss Jane's developmental issues. I explained that the developmental issue for Jane and for the family was intimacy, to learn to stay close, no matter what feelings surfaced. Mr. B agreed that intimacy was difficult in the marriage. Mrs. B wondered why they were still coming to therapy. After all, they had learned that Jane did not have autism, so why did they need this? They could play at home when it was convenient, not here, when it was scheduled. I empathized with the hard reality of the regimen but also noted how Jane flourished in sessions with her parents' undivided contemplation, and said we should keep thinking about any and all impediments to intimacy.

For the next two weeks, I joined the parents' preference to focus on Jane's developmental gains. Jane, crawling to get a ball, picked up the picture of a ball instead. She proudly stood on two feet like the humans, no longer moving on all fours like the cat. She created a teasing game with two balls, extending one towards her mother and then playfully withdrawing it. Jane,

I explained, had turned her passive experience of weaning, in which her mother controlled access to the breast, into active playful mischief, in which she deprived her parents. She was using play to help master feelings.

To enhance Jane's comfort with aggression, the aggression mobilized by weaning, I made available a toothed and clawed dinosaur puppet. Jane picked it up, scrutinized the teeth, then dropped it, and chewed on the cat puppet presented by Mrs. B. Mr. B picked up the dinosaur and roared fiercely. Jane startled and looked scared, and Mr. B, less loudly, roared again. Jane watched, trembled, and then sneezed several times. Jane, I said, was still learning to handle the excitement of having teeth and biting, and through play, she would become more comfortable with these impulses. Mr. B, expanding on my invitation to play, had the dinosaur eat mother's toes and then playfully growl and nibble up her leg. Jane watched intently, still somber and scared, and then looked up at mother's face, which was blank. Jane, I said, wanted to know her mother's opinion of the biting. Mother explained that last night while nursing, Jane had bitten her breast and mother had impulsively yelled ouch and scared Jane. We discussed Jane's need to adjust to the repercussions of her biting, a powerful new action.

Later that session, Jane pushed herself to stand and then gently let herself down. I highlighted her competence in self-regulation, recalled her early difficulties moving into and out of arousal states, and congratulated the Bs on teaching her this self-control. Jane repeated her exercise several times and I praised her strength. Mother anticipated that by 18 months, Jane could start gymnastics, an activity through which she could meet other children. Then mother began a new game, encouraging Jane to walk to her, and then sending her back to father. Father helped her return and Jane dove into her mother's arms. Mother scooped her up, laughing and hugging her daughter, and then let her toddle back to father. With increasing pleasure and excitement, the family repeated this game, father delighting in their daughter, but for the first time, mother leading the family in playful joy. I noted that Jane, with her parents joining to help her practice a new skill, all celebrating together, had everything she needed.

As this game ended, Jane reached for father's cell phone on the couch. Mr. B explained that Jane would have no gizmos or gadgets, and mother helped her sit on the floor and gave her a cup of water. Jane proudly looked at me as she drank by herself. With the session's end near, father and I began to pick up and say goodbye to the toys, Jane ignoring father's request for the cat puppet in her mouth. Mother said that Jane did not want to leave, and I agreed that it was hard to stop, especially when everyone was having so much fun. Father teasingly placed Jane's little hat on his adult head, and Jane screwed up her face. I noted her confusion at father's joke, and mother came to Jane's aid, playfully reminding father that Jane didn't like his trick, it was Jane's hat. Father removed the hat and mother put it on the proper head, then bundled Jane up in her snowsuit. The family left, Jane flashing me a big smile.

Afterwards, I reflected on how relaxed this session had felt, as if I had been sitting with ordinary parents delighting in their ordinary almost-one-year-old, celebrating together the advent of walking, relieved to have survived the ordinary trials of infancy. At the session's start, Jane had bumped her head, cried, reached for her mother, and then quickly calmed when mother soothed her with tender reassurance and helped her return to play. Father comfortably set limits, and Jane cooperated with her parents' re-direction. True, Jane was still hypersensitive to strong feelings, and Mrs. B was frightened—virtually paralyzed—by aggressive play and disturbed by Jane's biting. But, for now, Jane's development was proceeding well and the menace that had once terrified the family seemed far in the past.

Next week, mother canceled because Jane had been sick and needed to sleep. The week after, Mr. B called to say they had decided to stop therapy. Several times he said that our work had been very helpful, that he and Mrs. B appreciated all I had done for the family, and that they were pleased with how well Jane was doing. They were watching for problems, but their schedule, he nervously insisted, was too hectic to allow sessions. I agreed that the family had used therapy exceptionally well and offered a meeting to review all that had happened. Father said they were too busy, but appreciated my offer of periodic check-ins to monitor Jane's progress, and would talk with mother and call if interested. Then he asked at what age one no longer worried about autism. I listed the milestones ahead—language, pretend play, and separation-individuation—and reminded Mr. B that I would be glad to help them track Jane's progress.

Although I have not heard from the family, the pediatrician reports that Jane, at 18 months, was doing well and that the family was eager to put the early troubles behind them.

DISCUSSION

Here, I discuss four issues: containment as the mechanism of treatment; the elusive concept of autism as I will define it below and whether Jane's defenses were leading to an autism; factors in the parents' abrupt departure; and, briefly, the possible role of the parents' predilection for information technology in Jane's choice of defenses.

From the beginning, Jane and her parents found the therapist's contemplative mind a calming influence. The parents had slipped into a vicious cycle of helplessness, panic, rage, and guilt, culminating in a conviction that Jane was a permanently damaged child. This fear, or fantasy, had damaged the family's reflective function, the fantasy being composed of what Bion (1962) might have called "beta" elements. The therapist, unpersuaded by fatalistic views of autism, was able to digest the fantasy analytically and return it as "alpha" material for the family's contemplation. Fonagy and colleagues (2002) refer to this process as reflective functioning, a mechanism by which parents promote the infant's secure attachment. As Jane's parents processed some of their own panic, they could begin to contain their daughter's terror and rage. They began to meditate on the workings of Jane's mind. They grew more empathic toward her, and more aware of how their emotional states affected her. The parents also used therapy to process marital conflict, saving potentially polarizing conversations for the safety of the office, trusting that this protected space would support thought instead of destructive reactions. Jane's favorite toy, the cloth birdhouse into which she placed and removed the brightly colored birds, might have symbolized the mind into which she and her parents could put their feelings, a three-dimensional mind, with an inside and an outside. Jane in particular became eager to learn about other minds, to share her feelings and wishes and, to implement these great projects, to use words. Likewise, the therapist, awed by the opportunity to help such a disturbed infant, found a reflective mind in her consultant, Dr. Acquarone.

Jane's recovery was dramatic. From frantically rejecting other people, she hungrily pursued human contact, first with her therapist, then with her father and eventually with her mother. Her stuporous withdrawal gave way to lively, searching eye contact, through which she assessed her parents' reactions and drank in the pleasure of shared feelings. The advent of stranger anxiety and a calming response to Mrs. B signaled her readiness to lean on her mother for comfort. Jane's self-stimulation—a typical autistic substitution for interpersonal comforts (Tustin, 1981)—and

self-directed anger disappeared. As she reposed upon her parents for reassurance she became happier and less anxious, and modulated her startle reflex. Instead of the primitive coping strategies of pulling her hair to remove troubling thoughts or, perhaps, to turn sadistic impulses round onto herself, Jane began to tease her mother in order to symbolize and regulate, for example, her frustrations around weaning. By the end of her first year, she appeared to be a typically developing toddler, interested in her parents' minds, communicating with gestures and even some words, and playing with her parents. The specter of autism that had haunted her parents' minds seemed to have vanished.

I took particular interest in Jane's tendency to withdraw and to become mesmerized by visual sensations—a rotating light, fluttering leaves, “white snow” on the television screen. Tustin (1981) described such sensations as autistic shapes, masses of motion that fill the chasm felt between baby and parent. Studies of infants who later develop autism often point to this symptom, a difficulty in disengaging visual attention (Zwaigenbaum et al., 2005). (But this symptom is neither specific to, nor necessarily predictive of, autism; N. Yirmiya, personal communication, May 29, 2013.) As Jane increasingly recruited her parents to help regulate her emotions, she relinquished sensuous objects, or, when drifting toward them, could be recalled by her parents. Electronic gadgets, however, continued to mesmerize her. Several questions arise: Was her hypnotic propensity biogenetic, or a derivative of prenatal influences, or some interaction of the two? Was it the residue of a defensive style she chose very early, chosen in part to adapt to a biological vulnerability? Does the technology itself invite stupor? Or was she identifying vengefully with her parents, holding up a mirror to them, that they might reflect on their own overattachment to gadgets?

Jane's sensitivities may have predisposed her to overstimulation and, hence, withdrawal. Her parents remembered her as always startling easily. This reactive temperament—the result of genes, a sensitizing of her stress response system during exposure to prenatal stress, or interactions among these factors—may have predisposed Jane to extreme and abrupt reactions to her parents and to inconsolability. These impairments, and the reactions her parents had to them, increasingly dysregulated the infant-parent interactions. Jane became psychologically isolated and unable to regulate her distress; she fell back upon more dissociative types of emotion regulation (see Beebe et al., 2010, for description of four-month interactions associated with the development of disorganized attachment). These dysregulated interactions would have amplified her overreactions. Fortunately, Jane became more resilient and consolable as her parents pondered her distress, as her attachment with her mother blossomed. Once Jane found emotional safety with her mother, she took interest in her mother's face, searching for the maternal emotions. So, I did not see evidence of difficulties with processing facial information typical of infants who are later diagnosed as autistic. Instead, it seemed that Jane's interpersonal aversion arose from painful interpersonal relations, that is, attachment difficulties. As these improved, Jane engaged her parents. Was Jane also withdrawing from the continuous, loud electronic media noise in the home (see below), acoustic stimuli not attuned to her?

While Jane's behavior was consistent with attachment difficulties, her tendency to withdraw and her difficulty disengaging from visual stimuli resembled descriptions of autism or an autism spectrum disorder. This left me wondering if Jane might be headed towards autism. I am defining autism, in this article, as impaired social communication and interaction and restricted, repetitive patterns of behavior, interests, and activities (see Gensler, 2012). These phenomena were formerly described as autistic withdrawal, a progressive and insidious rigidification of the stimulus barrier

aiming at the mental impregnability we see in severe cases. Tustin (1981) described children who experienced a premature rupture in the symbiotic bond with mother and turned to autistic shapes and auto-generated sensations to fill the gap in maternal contact. Tustin called this type of autism psychogenic, a phrase that suggests a psychological pathway to autism; but she allowed that neurological factors could predispose the infant to experience ordinary frustrations as interpersonal ruptures. Later, when Tustin (1991, 1994) retracted the idea of autism as a normal developmental stage to which the autistic child regresses, she retained her view of psychogenic autism as an adaptation to a traumatic rupture of an abnormally-fused mother-infant bond. In this psychodynamic tradition, Reid (1999) also suggested that early psychical trauma could lead to autistic defenses of withdrawal. How can these psychogenic theories, and the intimations of a psychological pathway to autism suggested by my work with Jane, harmonize with contemporary scientific views, views that, since the 1970s and until recently, have narrowly emphasized the organic, and especially genetic, causes of autism?

The revolution in brain science has clearly demonstrated brain plasticity and confirmed the perpetual transaction between genes and environment. These findings support more complex theories of autism's cause (for a recent review, see Yirmiya & Charman, 2010). Researchers still view autism's cause as largely unknown, but they envision various paths, or network of paths, to the behavioral syndrome of autism. To seek a single cause or a single developmental trajectory is today considered fruitless and obscurantist. Increasingly, researchers talk about autism in the language of gene-experience interaction, experience including social influence (Elsabbagh & Johnson, 2009; Yirmiya & Charman, 2010). For example, prospective studies of babies considered at high genetic risk, specifically baby siblings of autistic children, found unexpected fluctuations in the babies' social interest; no standard timing in onset of autism; and language and cognitive delays which spontaneously reversed. Some researchers interpret these findings as reflecting "random variation in genetic timing" (Rogers, 2009, p. 134), but others consider them persuasive evidence for environmental influences on the expression of genes (Elsabbagh & Johnson, 2009).

Partly as an outcome of this new sophistication, the scientific community is now recognizing the possibility of recovery from autism. Contradicting earlier genetically deterministic views of autism, researchers have shown that developmental-behavioral intervention can normalize brain activity in autistic preschoolers (Dawson et al., 2012) and theorize that early identification and intervention can prevent autism (Dawson, 2008). Two recent reports described children with confirmed diagnoses of autism (diagnoses were made at an age when autism can be reliably diagnosed—not during infancy) who later showed no signs of the disorder (Sutera et al., 2007; Fein et al., 2013), inspiring an editorial on the "science of hope" (Orzonoff, 2013). Autism is no longer despairingly dismissed as a chronic and unchangeable neurological impairment.

The hopeful discoveries of brain plasticity and social influences on brain development also broaden possible interpretations of the structural and functional abnormalities associated with autism. Yirmiya and Charman (2010) review several of these abnormalities and discuss their interaction with environmental factors. The authors note, for example, that the pathognomonic acceleration of brain growth during the first year of life occurs during a phase of rapid synaptogenesis and pruning, a process shaped by the infant's experience. In addition, they point out that autistic children have shown enlarged amygdala, especially in the right-hemisphere. The amygdala is active in reading facial emotions and orienting to eyes. It is not known whether gaze

aversion or abnormal brain structuralization occurs first, but researchers hypothesize that abnormal amygdala-mediated processing of social information may be one of the early difficulties that lead to the neurodevelopmental outcomes associated with autism. They cite Mosconi and colleagues (2009) and Dawson and colleagues (2004), who theorize that infants who will become autistic are less gratified by typical interactions with caregivers. Is it possible, the reader of this review might wonder, that in some cases these interactions are even painful? Schore's (1994) description of the influence of emotion-laden attachment experiences on right-hemisphere brain development might have an important bearing on this ongoing discussion. It seems plausible to this author that much of the science just described is consistent with so-called psychogenic theories of autism. Psychological experience is now accepted as a regulator of brain chemistry and gene expression and considered a possible etiological factor in autism (Levy, Mandell & Schultz, 2009). Moreover, neurological deficits, including those from genetic mutations, can expose an infant to terrifying gaps in the experience of maternal containment. The field seems to be gradually recognizing complex interactions between genes, physical and psychological environments, and brain structure and function. The claims of heritability remain strong, but evidence for environmental influence is growing.

How do these scientific trends inform our understanding of Jane's case? First, we will consider Jane's diagnostic ambiguity. Was Jane, in addition to her clear attachment difficulties, also headed toward autism, as I defined it above? In the negative, I point out that the impressive assertiveness of her protest distinguished her from many children who are eventually diagnosed with autism (S. Acquarone, personal communication, June 10, 2013). Nor is her history typical of infant siblings of autistic children who later became autistic; they showed normal social interaction before 6 months, with subtle difficulties appearing by 12 months (Rogers, 2009; Yirmiya & Ozonoff, 2007). In contrast, Jane showed dramatic early distress. By five months, she refused to mold into her parents' arms and strenuously tried to hurl herself to the floor. After eye contact with her mother, Jane would vigorously rotate her limbs, an activity reminiscent of Bick's (1968) descriptions of the "second skin," self-generated sensations that hold the personality together, a psycho-physiological integument that replaces the porous maternal containment and defends against passive helplessness. By pseudo-independence, Jane triumphed over helplessness. Her protest was so vehement as to drive her parents to therapy and to force them to establish a real relationship with her. This important strength distinguished her from, and made her more accessible than, most autistic children.

On the other hand, some of Jane's behaviors and aspects of her history reminded me of Tustin's description of autism. Jane had a propensity for hypnotic-like states in which she used visual sensations as autistic shapes, and she initially showed other behaviors typical of preautistic infants: a vacant stare, absence of social interest, and inconsolability (Chawarska, Klin, & Volkmar, 2008). These behaviors were profoundly disrupting Jane's social development, depriving her of the pleasurable exchanges of affect and eye contact, social exchanges required for the maturation of brain regions used in nonverbal communication and emotion regulation. Similarly, Jane's early habit of fixing her gaze on a particular object or visual sensation, without shifting from the object to check her parents' reaction, was costing her the psychological inputs needed to "hard-wire" her brain for intersubjectivity and shared cultural knowledge.

Jane's history included events that she, especially with her sensitivities, might have experienced as premature ruptures of the symbiotic maternal bond: psychical caesurae caused by a

long and traumatic birth, lapses in maternal preoccupation, the privation of reverie during nursing, and the parents' uncontrollable argumentation. Additional evidence suggested that she may have experienced something disturbing in her relationship with her mother. Most striking during our early meetings were Jane's violent rejections of eye contact with her mother, reactions that I never observed toward her father or myself. When she made eye contact with her mother, Jane would avert her gaze, freeze, or stimulate herself. These defenses are typical sequelae of trauma and suggest that Jane's relationship with her mother had been disturbed. I wondered if she had experienced a premature interruption of communion with her mother, a schism her hyper-reactive temperament may have amplified into a shattering disappointment of her pre-conception of intimacy.

To Jane's parents, her bizarre behaviors signaled autism. The terror this engendered, along with rage and sorrow, polarized their reactions toward her. They were constrained to either over-stimulate her—to draw her out of her stupors—or withdraw from her in despair. Neither of these reactions could fail to exacerbate Jane's maladaptations. Jane and her parents had become entangled in a vicious cycle, fueled by Jane's increasingly disturbing defenses and their dire meaning to her parents, a cycle from which they couldn't extricate themselves. The Bs themselves believed that their daughter's serious troubles would have persisted, but for psychotherapy.

Given Jane's young age and her rapid response to intervention, I myself never considered diagnosing her as autistic. But I kept wondering. Would Jane, had her defenses remained entrenched and her increasingly depriving style of interpersonal interaction persisted, have ended up with a diagnosis on the autism spectrum? (Another infant, differing from Jane in having oral-motor problems and food refusal but resembling Jane in early-onset strong startle response, difficulties transitioning between states of arousal, "checking out," arching, and breath-holding during his first six months, was diagnosed with autism by 15 months; Dawson, Osterling, Meltzoff, & Kuhl, 2000.) Was she headed for autism, as I have defined it?

In considering the relationship between attachment difficulties and autism, we should remember that most children who experience attachment difficulties, or even attachment disorders, do not develop autism-related difficulties (N. Yirmiya, personal communication, May 29, 2013). During infancy, attachment difficulties can be distinguished from a prodromal autism by the observations that symptoms appear predominantly in the attachment relationship and that the symptomatic infant is hungry to relate and relatively open to human contact. Nonetheless, this distinction allows the possibility that some children who later develop autism have had earlier relational problems, or a combination of biological vulnerabilities and relational trauma (N. Yirmiya, personal communication, June 6, 2013). That is, although autism and attachment difficulties are distinct, they might, in some cases, share certain early etiologic factors. In these situations, autistic defenses might supervene, and eclipse the attachment problems, which would nonetheless survive as an occult pathogenic force. Older children, having embedded the effects of disturbed attachment relationships in their evolving personalities, might present deceptive diagnostic pictures, concealing their distinct infancy presentations. Maybe we should refine the behavioral phenotype of autism spectrum disorder to include subtypes with distinct etiologic pathways. Or, maybe we should make an autism diagnosis only after assessing the child's response to intervention. (The Romanian orphans had autistic behaviors, but they responded rapidly to their new environments and were subsequently considered to have had attachment disorders; Rutter et al., 1999.)

I have some concluding thoughts about the fortunate outcome of the treatment. Jane's defenses were modifiable. The speed and ease with which Jane relinquished her defenses were likely a function of her extreme youth, her parents' strengths—strengths apparent in their seeking treatment—and the apparent absence of pre-existing neurological deficits. Not all infants who look preautistic, therefore, can be expected to respond to infant-parent therapy as Jane did; the response will depend on the source of the difficulties and the extent of neurological damage. But the case study suggests at least this conclusion: profoundly maladaptive defenses in infants are remediable.

Jane's case also illustrates the technical challenges of parent work in the context of infant-parent psychotherapy. Without question, Jane's parents evolved during the treatment. They learned to better manage their own intense affects, emotions often evoked by Jane, to think about Jane, and sensitively respond to her. Eager to be competent parents, they sought and followed my advice, gave Jane more playtime and predictable routines, and became curious about the workings of her mind. Mr. B became more confident in Jane's frustration tolerance and more comfortable setting limits. Mrs. B's preoccupation with her own disappointment gave way to genuine empathy and concern. Both parents, partly through identification with the therapist, partly through insight, discovered their own ability to parent.

Given these positive developments, the parents' elopement stunned me. Upon reflection, I came to appreciate tensions between the parents and myself partly generated by the ambiguous nature of the contract of infant-parent psychotherapy, tensions that we could not articulate or reflect on, let alone resolve. The Bs came to therapy as a way to save themselves and their daughter from autism, and once she was declared "normal," their goal was achieved. I had somewhat different motives. Like the Bs, I wanted Jane to connect with her parents and get the nourishing interactions essential for her mental and social growth. But my therapeutic ambitions extended beyond Jane; they included deepening her parents' understanding of themselves as parents. To my psychoanalytic mind, helping Jane's parents reflect on their own longings and anxieties was essential nutrition for the family's growth. I thought that enriching their self-knowledge would build their emotional strength and flexibility, preparing them to help Jane navigate the developmental challenges that lay far beyond the end of treatment.

We successfully formed an alliance around reaching Jane, and in the process, the parents dipped into their painful reactions to her. I quickly discovered how uneasy this made them. On the three occasions when Mrs. B cried, she diverted our attention with zeal. We could not discuss her shame about her need for emotional support. Mr. B seemed more comfortable with his feelings, but he often drew a veil of jokes and sarcasm over his fear and anger. He believed that his heart would break were his daughter to be angry with him, and both parents were afraid of marital disagreement. Thus, despite these glimpses into their inner lives, the Bs never reconciled themselves to my goal of better understanding themselves as parents. Stung by their rebuffs of my occasional efforts in this direction, I increasingly felt I was walking a tightrope, trying on one side not to shrink from opportunities to encourage their self-discovery, and on the other not to offend or wound their sensibilities. It was easy to misstep and lose my balance, and sometimes I did.

When Jane was pronounced free of autism, the mismatch in our treatment goals grew more conspicuous. The parents created one obstacle after another. They cut back on sessions, took phone calls during sessions, and ignored my inquiries about their experience of parenting. They seemed to interpret my curiosity as an arraignment of their parenting of Jane. Guilt and fear of

blame hung in the air, without a voice or name. In this atmosphere, it was hard work to preserve the reflective space we had once enjoyed.

Our interactions became increasingly dysregulated—me returning to the importance of understanding barriers to intimacy; the parents insisting that we focus on Jane’s development; and me returning to the search for entrees to deeper work, even as I maintained a focus on Jane. The parents probably experienced me as intrusive, unsympathetic to their career aspirations, and deaf to their reproaches. So they left. They did not forget their gratitude, but the tensions in our relationship inhibited their expression of it. Mr. B did thank me for Jane’s improvement and the family’s new happiness in a final phone call, but apparently the Bs didn’t feel safe to discuss this, or their decision to leave, in person.

In pondering this case, my thoughts kept returning to the problem of exclusion, the universal fear of ostracism from social groups, from relationships, from intimate contact with other human minds.

The case began with Jane actively excluding her parents from her mental life. Her parents worried she had a mental illness, which, they must have feared, would stigmatize them and exclude them from the community of “normal” families. Mrs. B seemed sensitive to the danger of exclusion and said she could not bear Jane’s nighttime cries, frantic sobs when Jane felt excluded from her parents’ bed. I wondered if in her early troubles with Jane, she was unconsciously repeating unremembered childhood exclusions of her own. She repeated this actively, when she shut out Jane with her own preoccupations, and again passively, when Jane denied Mrs. B the intimacy she craved with her daughter. Mr. B also worried about exclusion and said he feared a rupture in the marriage. I as the therapist felt excluded by the parents’ guardedness and by their abrupt departure. Metaphorically speaking, exclusion was a hot potato that the participants in Jane’s life passed back and forth among each other.

Could this sensitivity to exclusion help explain the Bs’ preoccupation by information technology? Cyber-excitement has swept through the culture, driven perhaps by a poorly understood, spreading fear of social isolation; and our technological adaptation to that fear is making more remote the very intimacy we seek (Turkle, 2011). By the Bs’ report, ring tones and one-sided cell phone conversations dominated the acoustic field of their home, and a video display of multiple television channels ceaselessly bombarded them. When, at my recommendation, the Bs briefly stemmed the torrent of images and sounds that flooded their home, Mrs. B felt, she reported, like screaming. I wondered privately if this impulse expressed a terror of solitude, a dread of being left in her own company, cut off even from cyber-companionship. I wondered if the stream of stimuli, stimuli unattended to Jane, had contributed to Jane’s resolve to build an inflexible stimulus barrier?

Jane’s story warns us against oversimplification and overreliance on the theories of the day. Her impairment no doubt had multiple sources, and its final path, had Jane not gotten early help, remains unknowable. But this little girl and her parents had a resiliency unavailable to many children and families. She dramatically protested a relationship that she experienced as painful; she refused to drown without a fight, and scared her parents *into* psychotherapy. If Jane had passively withdrawn, or the parents had been more complacent, her troubles could have become entrenched. Jane’s parents, for their own part, however guarded they were, drew upon their own strengths and their love for their daughter, and capitalized upon this crisis to develop their own parenting capacities.

This case has left me with a lasting worry, or hope. It is typical of infant-parent psychotherapy, when the parents have not presented themselves as patients, to facilitate the child’s development,

but to leave the parents' deeper personal fears alone. Gone are the days, for better or for worse, of insisting on individual treatment of the parents as a necessary part of helping their troubled children. Indeed, we do seem to have become more efficient in treating distressed families and in recruiting the parents' ego capacities to promote their child's growth. For this evolution in technique, an adaptation of psychoanalytic thought and technique to the family setting, capable of reaching infants like Jane, we can be grateful. But who cannot also hope, seeing so much mental business left unfinished, that the better angels of these parents, and perhaps all parents, will some day catch their consciences and lead them back onto the path of self-knowledge?

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