

**Alonim A. H. (2007). Signs of Autism in Infants – Recognition and Early Intervention. "Infants at Risk – Early Signs of Autism – Diagnosis and Treatment". Chapter 7, Karnac Books. London**

In the late 1980's, when the age for diagnosing autism was lowered to three years old, this was considered an early diagnosis. In the late 1990's, when the diagnostic age was lowered to two years old, this was considered not early enough.

Over the past eighteen years of interviewing parents of children diagnosed with the autism spectrum, the same words have been heard time and again: "My child had a completely normal development until the age of one year, and then I began to notice regression..."

The crucial question is then: what happens during those months of transition between the first year of life and the second that causes regressive processes in cases such as these?

Basing our knowledge on a theory such as that established by Mahler (1968), who approaches the process of a baby's emotional development based on three stages - the autistic stage, the symbiotic stage and the separation-individuation stage - a number of hypotheses may be constructed to explain this thin line that divides between the first and the second year of a child's life, and they may subsequently be refuted.

Over the last decade, research has been carried out of the first year of life in children treated at the Mifne Center, which incorporates a program using therapy for young children with autism and their families.

The most comprehensive and reliable data is provided by the parents. The mother says, "I remember when he was ten months old he used to look at me and smile", while the father retorts, "I don't remember he did anything like that".

On the other hand, a mother occasionally admits, "From the beginning I felt something was wrong with my baby, but everyone told me I was being a hysterical mother"...

Deep inside them, mothers know what scientists discover – that relationships between babies and mothers are mutual...



Diagram No. I

Diagram No. 1 (devised by the Mifne Center) represents a family setup in general. It shows the family constellation into which the child is born, as well as the reciprocity between the two systems, mother – child, that are influenced by broader ones.

## Method

The initial attachment process between a baby and its parents (Bowlby 1969), especially with its mother, whether she is aware of it or not, confronts the mother with her own early childhood experiences and with those initial and most significant objects in her own world.

To understand the baby's characteristics the inner world of his parents must first be understood (Winnicott 1956).

An increasing number of families arrived at the clinic for their initial interview, equipped with extensive documentation about their baby from the moment of birth. This material is fascinating if scrutinized carefully. The symptoms observed in some of the babies were minor, implying that the majority of parents would probably not notice any irregularity. When watching the videotapes of these babies from an analytical aspect however, it is possible to collect data indicating warning signs, or what will be called "red flags".

One of the most interesting pieces of documentation came from a family who runs a circus. The parents sent a lengthy video showing pictures taken from the birth of their son until he was three years-old. They mentioned in their accompanying letter, “As you can see, our son was a normal child until that awful thing happened...”

The “awful thing” that happened was this: Following a performance by elephants in the circus, the music stops and a little boy with golden curls gets up on the stage, dressed in a suit and bowtie. He is brought over to center stage and the audience starts clapping madly. Apparently this is the child’s very first performance. The child suddenly becomes paralyzed, immobile until his father eventually has to carry him off of the stage. In an acute way, the child shuts off and becomes introverted, and during the rest of the video he does not utter a sound.

An episode like this can definitely be traumatic to any child. And yet, when examining the earlier stages of his life more carefully, it is possible to see for example, when he is still a baby, that his father over-exerts himself every time he wants to attract his attention, and it takes the baby some time to turn his head towards him; that the baby enjoys concentrating on one object for longer than normal.

The parents who each had children from previous marriages, were unaware that anything was wrong. However this child, who is a teenager today, is severely autistic.

On rare occasions parents insist they can pinpoint a traumatic episode that triggered their child’s regression – a car accident, abandonment, abuse, and the like.

In the majority of cases, evidence is non-existent, in spite of the claim by various international forums in recent years regarding the detrimental effects of vaccinations and mercury.

It is important to note that in ultra-orthodox Jewish circles, where most of the people do not vaccinate their children in principle, there are no fewer cases of autism, and some families even have more than one autistic child in the family.

In November 2003, the American Health Ministry published statistics indicating that 1:250 children are diagnosed with the autism spectrum.

At the NADD conference in Vancouver in November 2004, a statistical estimate of 1:166 was given for the USA (mainly in California) in comparison to the statistics from 1990, which showed 2:5,000.

There are a number of reasons for this dramatic rise:

1. Increased awareness and a wider exposure of the syndrome
2. A broader diagnosis of PDD in the DSM IV, and especially Asperger
3. More advanced examination procedures; improved techniques (like ADOS)

4. Political aspects of resources, especially in the US, where people prefer to have a diagnosis of PDD, rather than any other child developmental disorder.
5. An authentic rise that has no empirical explanation as yet.

The American Health Ministry publication declared, “Don’t wait for a late diagnosis; start treatment when children are already a year and a half, when you notice the red flags”...

According to the Mifne perception, they should already be pinpointed during the first year of life.

### **Detection**

When approaching diagnosis during the first year of life, we should be cautious and use the term “attachment disorder” which may develop into a syndrome diagnosed as the autism spectrum.

There is no comparison between the effect of intensive treatment on an eight month-old baby and an infant aged eighteen months. The developmental process of the brain during the first year is the most dynamic in our entire lives. The baby is exposed to stimuli that have a decisive effect on cell growth. This is a stage that never returns. The early signs in pre-verbal infants during their first year of life, as identified at the Mifne Center, relate to an ongoing disorder in attachment development during the first year of life.

### **Red flags:**

#### 1. Excessive passivity

Lack of crying, immobility, lack of interest in surroundings.

These babies have an overt tendency to passivity and do not achieve those crucial stepping stones of initial interest in their surroundings, as can already be seen from two and a half to three months (Stern, 1985). According to Stern, babies discover and show social motivation from the age of two months.

We often hear it said, “My child is an angel, He never cries”, “We didn’t know there was a child in the house, from the start I slept through the night....” In a number of cases of girls like these, the parents mentioned that because their first child was a boy and very active, they simply thought girls were different.

#### 2. Excessive activity

As with constant crying that has not had a medical diagnosis, this represents a lack of physical calmness, which is a symptom at the opposite pole of the previous point (no. 1).

It is interesting to note that some children who were obviously passive, became hyperactive during their second year of life. A study by Professor Volke (2002) indicates that babies who cry incessantly are more likely to become hyperactive.

An eight-month-old baby was examined in the diagnostic unit at the Sourasky Medical Center in Tel Aviv. The baby was born premature, his head holding was still unstable, he was agitated and cried constantly when he was awake, it was very difficult to calm him down but when he was carried to and fro he quietened down somewhat. All the tests came out negative, although a metabolic disorder was suspected. The baby appeared to be in a state of total irregularity, lacking a sense of self, his entire body transmitting the message "I don't want to be here"...When asked how she is coping with this situation, the young mother replied, "Even before I became pregnant, I knew I'd have a disturbed child"...

### 3. Refusal or resistance to feeding or nursing

A high percentage of children treated at the Mifne Center who were diagnosed with the autism spectrum, had already shown an inability to adapt or regulate their eating habits during their first days of life, or at least during the first months.

It is interesting to monitor these children whose sense of smell is so delicate and who tend to smell every object, especially foods, and to hear from the mother what took place from the very beginning. Some mothers report that their baby screwed up his face in a way that expressed disgust by the smell of the breast. What is the reason for this aversion and what could be the cause of this lack of attuning?

One mother whose baby refused to nurse from her, requested the assistance of her friend who was feeding her baby at the same time. She was shocked and upset when her baby did not refuse to nurse from her friend. A baby of only three weeks old is already able to distinguish between one nipple and another. The experiential model that should have developed both in the baby and in his mother, became a negative intersubjective experience.

### 4. Lack of reaction to a voice or presence of a parent

The baby does not turn his head, and neither smiles nor babbles.

The first detail that must be tested thoroughly is the child's hearing. In most western countries, gone are the days when babies with attachment disorder were diagnosed as hearing-impaired and treated with hearing aids.

Some of the first children treated at the Mifne Center had also been treated within the Israeli education system for hearing-impaired children because they were considered hearing-impaired, after having been diagnosed with a BERA test.

It was interesting to note that the test, which is supposed to be objective, offered a clinical picture of a decrease of about 50 decibels, which was later discovered to be inaccurate. At least two of the children could easily hear sounds of less than 50 decibels if they were interested in what they were hearing, and later on, it was found that their hearing was oversensitive.

In her doctoral research about infants who underwent a cochlear implant, Dikla Kerem, who works with hearing-impaired children, notes that infants are liable to feel flooded during the first year with the implant. She has seen children intentionally removing the outer part of the instrument to cut themselves off from the noisy world and return to the familiar and "secure silence".

Does audio sensitivity, then, cause gradual disassociation? According to Francis Tustin (Tustin 1992) a psychoanalyst and important researcher in the field of autism, it most certainly does. A baby who responds to the presence of a parent, but not to the sound of his or her voice, will be assumed to have a hearing impairment, whereas a baby who responds to a voice but does not react to a presence, will be assumed to be indifferent or having developed a fear of the adult in question. Babies who suffer from fear or indifference to their surroundings do not usually begin to babble in the early stages. Babbling is a function of bonding in the same way as language is a function of contact.

##### 5. Aversion to parental touch (or any other person)

Brainwave tests show that the brain already responds to touch during the seventh month of pregnancy, which supports the assumption that the baby is capable of responding to attempts like these even when still in the womb. Sensitivity to touch begins in the facial area and gradually moves to all parts of the body. In reference to the previous category it is interesting to note that Tomatis (1977) developed an auditory method which relates to the skin as a continuation of the ear - the tactile part as one large ear! What was considered for years as a lack of sensitivity is now considered as oversensitivity.

According to Tomatis' theory then, just as the ear does not want, or is afraid to hear, thus the body does not want, or is afraid, to sense.

Tustin and Bion (1957) maintain that "flooding" takes place, and in their clinical studies of psychotic children, they found that an unbearable awareness of physical separation from the mother took place too suddenly and too abruptly for these babies.

As a result, the child experienced a disastrous sense of injury and physical damage, which may explain the aversion to touch.

#### 6. Lack of direct eye contact (eye contact exists with objects)

Making eye contact is not easy. There are people who find it hard to look a person in the eye. More than any other part of the face, the eye is the most sensitive, the most revealing, the most self-conscious. The word “pupil” comes from the Latin word “pupa”, meaning doll. Stern maintains that interaction with another person develops the ability to have positive emotional experiences, whereas a response to stationary objects contributes to what Piaget defines as sensory motor development.

In the book entitled “Mother-Infant Attachment and Psychoanalysis – the Eyes of Shame”, Mary Ayers (2003) offers a fascinating theory about the eye of shame. She tries to understand what the baby sees when he looks into his mother’s eyes. She suggests that shame is a characteristic that originates from environmental failure, it is already deeply rooted in the early developmental stage that began with the meeting of the infant’s eyes with those of his mother, and that this has a decisive emotional effect on the rest of his life.

The following example will illustrate this point. A mother of a seven month-old baby arrived for a meeting. She claimed that because this was her fourth child and she had a great deal of experience, she sensed her child was not making eye contact with her. The woman, aged 40, was somehow familiar to me. Having told me that this child was unplanned, and that she was very much involved in bringing up her two and a half-year-old daughter, I then remembered where I had seen her. Some months previously, on a flight from the north to the center of Israel, she had been sitting beside me with her little daughter, playing with her during the entire flight in such a warm, clever and containing way. As I watched them, fascinated, I thought how lucky this little girl was to have such an intelligent and mature mother, and what a wonderful role model she made.

When I related my experience to her, she smiled. This incident is important to illustrate this aspect of her excellent qualities as a mother.

We were three experienced therapists who saw the baby at that meeting. He made immediate eye contact and smiled at each one of us. He followed our movements and was very inquisitive for a baby of his age. His mother behaved very warmly towards him, cuddling him. When she tried to turn his head towards hers, he immediately looked aside and began to take an interest in the objects on the floor. During the hour and a half-long meeting, she did not manage to make her baby make eye contact, and yet, shortly after she left the room, he began to cry; he may have been hungry. She immediately nursed

him. During the course of our subsequent conversation, she told us that her second son had died five years previously, aged four years old. She had become extremely anxious and had already been aware of her anxiety during the pregnancy. She vividly described how her first gaze into his eyes was full of fear and added, her voice full of pain, "I was also ashamed because I didn't want him..."

#### 7. Delayed motor development

This is often characterized by hypotonia and all developmental stages are delayed. Some children also have high stiff muscle tone. Yet this parameter ought not to represent a significant criterion, because some children who are later diagnosed with autism do indeed show an especially quick motor development.

It is important to note that many children with developmental disorders are built well physically, yet tend to have illnesses connected with breathing and metabolic difficulties.

#### 8. Rapid growth of the circumference of the head in relation to the initial point

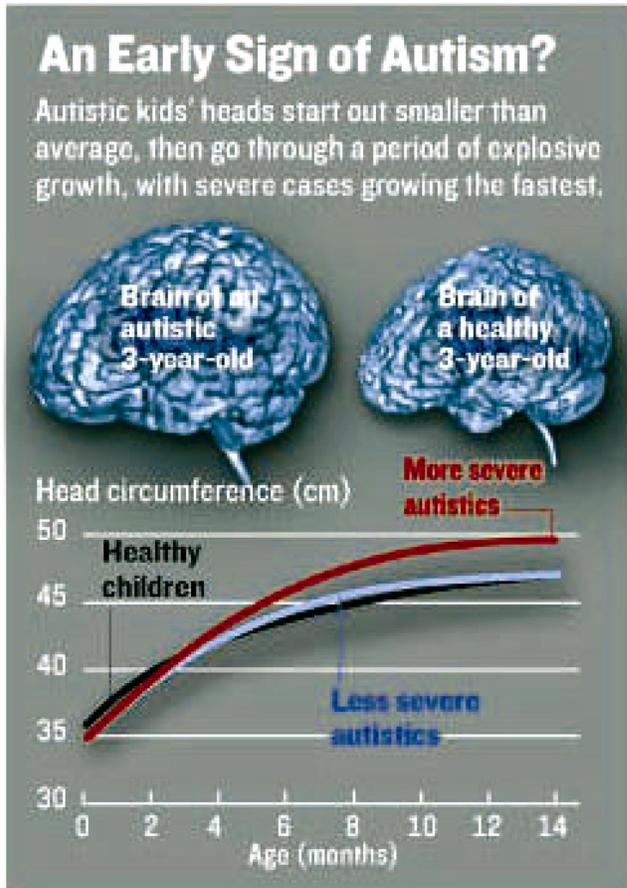
Prior to MRI, the developmental brain basis of autism was virtually unknown, but in recent years, MRI has revealed a distinctive pattern of growth abnormalities in cerebral structures.

Brain behavior evidence is consistent with the more general hypothesis that autism involves widely distributed aberrant functional organization in cerebella, cerebral and limbic regions, and these defects appear to underlie multiple cognitive behavioral deficits. One fMRI study found that autistic patients have robust brain activation to the mother's face in the posterior cingulate, a region thought to play an important role in normal human social emotional experience.

In his research published in 2002, Professor Courchesne (2003) compared forty-eight young children diagnosed with autism with a control group of normal children.

In the group of autistic children, the circumference of the head was smaller at birth, but during a year of growth, the circumference grew rapidly in comparison to the other group. The research indicates the phenomenon but is unable to show the reason for it.

Increased head growth can point to other problems that are unconnected with autism, such as hydrocephalus or Weaver syndrome.



An interesting definition is offered by Dr. Margaret Bauman, Harvard Medical School:

*“Normal brain development is not a monologue but a dialogue, in which the brain generates neural circuits and the child’s experiences determine which ones survive. The first year of life is a critical period for this experience-guided growth. The brain’s circuitry would expand haphazardly as cell growth outpaced experience, creating a chronic sensory overload, which could possibly explain sensory oversensitivity in such children”* Bauman, M., 2003)

At least two characteristics of the above eight signs must be present over a period of at least three weeks.

All the relevant medical tests should be carried out before testing for a suspected attachment disorder, while ensuring that there is ongoing interaction and consultation with all relevant parties.

The diagnosis unit for ‘Early Detection of Infants at Risk for an Attachment Disorder’ was established by the Mifne Center at the Sourasky Medical Center in Tel-Aviv. Infants, who are found to be high risk following their assessment at the unit, are referred to the Mifne Center for treatment.

## **Early Signs of Pre-Autism Scale for Infants – ESPASI**

Alonim A. H., The Mifne Center, Israel, 2005

**The scale is appropriate for infants aged up to 12 months.**

The observer should complete the scale immediately following **at least two clinical observation meetings** (one hour each, on different days and at different times of the day) **+ a videotape taken at home**. The same questionnaire should be completed by the parents.

Each item is rated on a scale from 0 to 5:

- 0 = **The sign does not exist** (during observations)
- 1 = **Doubt if the sign exists** (the observer is unsure)
- 2 = **The sign rarely appears** (once or twice in a meeting)
- 3 = **The sign does not appear consistently** (not in every meeting)
- 4 = **The sign appears quite often** (a few times during a meeting)
- 5 = **The sign is very obvious** (appears consistently).

### Early Signs:

1. **Excessive Passivity** (lack of crying, immobility, lack of interest in surroundings)
2. **Excessive Activity** (lack of physical calmness, incessant crying)
3. **Refusal or Resistance to Feeding or Nursing** (breastfeeding/others)
4. **Lack of Reaction to Voice or Presence of a Parent** (doesn't turn his head or smile, doesn't babble)
5. **Aversion to Parental Touch** (or any other person)
6. **Lack of Direct Eye Contact** (eye contact exists with objects)
7. **Delayed Motor Development** (followed by hypotonic/high stiff muscle tone)
8. **Rapid Growth of the Circumference of the Head** (in relation to the initial point).

**At least two characteristics of the eight signs must exist, over a period of at least three weeks.**

**All the relevant medical tests must be carried out before testing for suspected Early Signs of Pre-Autism.**

**1. Excessive Passivity**

0    1    2    3    4    5

**2. Excessive Activity**

0    1    2    3    4    5

**3. Refusal or Resistance to Feeding or Nursing**

0    1    2    3    4    5

**4. Lack of Reaction to a Voice/Presence of a Parent**

0    1    2    3    4    5

**5. Aversion to Parental Touch**

0    1    2    3    4    5

**6. Lack of Direct Eye Contact**

0    1    2    3    4    5

**7. Delayed Motor Development**

0    1    2    3    4    5

**8. Rapid Growth of the Circumference of the Head**

0    1    2    3    4    5    Initial size:    Present size:

Total Score: \_\_\_\_\_

## Evaluation of Rating:

0 - 6 -    No attachment problem exists

7 - 12 -    Recommend follow-up of the baby in 3 months' time

13-18 -    Recommend consistent guidance for parents

19-24 -    Recommend immediate weekly treatment

25-40 -    Should be referred for urgent intensive treatment.

Baby's name:\_\_\_\_\_ Date of Birth:\_\_\_\_\_

Address:\_\_\_\_\_ Phone\_\_\_\_\_

Observer's name:\_\_\_\_\_Date of Test:\_\_\_\_\_Place:\_\_\_\_\_

Signature

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## **The Mifne Method**

The Mifne (Turning Point) Center was established in 1987 (Alonim, 2004). This model of early intervention for autistic children in Israel was the first to recognize the importance of individual therapy, intensive treatment and parental participation. The approach is based on Bowlby's (1969) attachment theory, and it incorporates psychodynamic concepts introduced by Tustin (1981) and the systemic approach to family therapy of Minuchin (1974).

The Mifne Treatment Model (Alonim et al, 2004) is a sequential family program for young children and infants with a diagnosis of the autism spectrum and includes three stages:

1. Intensive system therapy for the nuclear family in residence at the Center
2. Follow-up therapy at the family home
3. Integration of the child into a mainstream nursery school .

The basic concept underlying the therapeutic model views the family as an organic unit.

The nuclear family takes an active part in the intensive therapy, which begins with a residential segment lasting three weeks, seven days a week. This is followed by an aftercare program when the family returns home.

The initial short-term therapy aims to give the family the opportunity reflects upon themselves and their child, to gain a better understanding of their needs. It identifies the parents and, in a broader sense, the nuclear family, as the focal point for treatment. Special attention is given to the siblings in the family, who are included in the program according to their age.

A retrospective evaluation of the program undertaken by the Schneider Medical Center (Apter, 2001) revealed that children showed improvement in almost all items on two scales: the Childhood Autism Rating Scale (CARS) and the Social Behavior Rating Scale (SBRS). Total scores on both scales confirmed significant improvement after a three-week period, and after six months.

Follow-up data shows that seventy-three percent of the children treated at the Center have been integrated in mainstream schools.

## **Intervention**

The individual sessions with the child are based on Reciprocal Play Therapy (RPT) developed at the Center, which helps the child to discover the pleasure of human contact and communication. The goal

of RPT is to engage the child by easing him into the experience of social interaction as a source of pleasure, by encouraging him to feel the comfort of unconditional acceptance, to enable the growth of trust and to stimulate the child's motivation to engage in social interaction.

The three stages of RPT proceed with:

**Tempted Play (TP)** – The therapist tempts the child with a favorite object, while the child can reach for it and may start to pay attention to the therapist working with him, who may then offer him another favorite item. This is the seed from which trust in the provider of pleasure grows.

**Sensory Play (SP)** – Gradually the therapist will sensitively touch, hug, massage or carry the child and try to comfort his body. Sometimes this leads to the first smile or cry.

**Cognitive Play (CP)** – This focuses on the development of basic skills such as looking for a toy, putting a block into a box, etc.

This is a cumulative process that is enhanced by, and incorporates, the elements of the previous stages. In addition to the process in the therapy room which is sparingly equipped, hydrotherapy is included to strengthen gross motor skills and improve spatial orientation.

Parents are present throughout the program and view therapeutic sessions through a one-way mirror. They also have separate sessions together with their child and are helped to become skilled observers of his behavior patterns.

## **Parents**

The parents are considered as the performers who fulfill the family ideology. The term “family ideology” incorporates the entire range of expectations, basic assumptions and beliefs, culture and family tradition, the roles of the family members and the means to carry them out. Family ideology is significant in consolidating the family structures and characteristics from within on the one hand, and in delimiting them externally on the other. When attempting to understand family ideology, we make use of terminology taken from the Intergenerational Approach (Nagy) and the System Approach (Minuchin, 1978).

The concepts may be generally described as follows: Two people - two worlds - bond in order to promote together "what is common" to both of them and while so doing, they attempt to bridge the gaps that exist between them.

During the consolidation of a family unit, the members must surmount various obstacles (the need for independence, the sense of loss of freedom, acceptance of responsibility...)

The intention is that the common aspects forming during the consolidation process between the couple be transferred to the next generation. A significant part of this experience is the bringing up of children. A child who is different confronts the parents with a difficulty. Lack of feedback from the baby might cause the parents to feel a sense of failure in the main mission they have taken upon themselves, both individually and as a couple. The couple mobilizes the joint means taken from their family ideology, in order to cope with the difficulty. When these means are perceived as ineffective, the parents undergo a gradual process of regression. This regression is expressed by searching for individual means to cope. It leads to the widening of the personal gaps between the parents and causes the natural family formation process to come to halt. Regression increases the adherence to individual mechanisms based in the personal biography (defense and coping mechanisms) and may reduce the functional ability of the family.

A family in a state of insufficiency is dealing with a struggle to survive. This struggle, which leads to a secondary consolidation - the focal point being the special baby - leads simultaneously to an internal-individual ingathering of its components. In many cases, families adopt a style of ambiguity, which affects the family communication system on the one hand, and causes confusion on the other. Confusion might increase the emotional detachment of the infant. The family finds itself in a vicious cycle and seeks help.

The therapeutic environment, based on principles of a bio-psycho-social model, attempts to encourage the gradual evolution of the child and each family member towards individual and mutual growth.

The family program is designed to help the parents understand the basic principles of the method, which serves to improve their awareness of their life and needs. The work with the parents aims to enable them to broaden their ability to achieve an insight into themselves, to understand their own behavior as an outcome of the way they perceive themselves as individuals, and as a part of a role dictated by their family ideology.

The Mifne method uses a variety of techniques such as clinical meetings, verbal and non-verbal communication, individual and joint couple meetings, family sessions, feedback and team consultation with the parents. One of the strategies applied by Bollas' (1987) concept of "unthought known": what you do is based on what you know, but are not always aware of.

In the course of these sessions, a number of questions are directed at them:

How do both of you feel in encounters with your child?

How do you cope with this experience?

What do you do with these feelings?

What have you been doing up till now?

What have you not done?

What would you like to do? Why?

What do all the things you have done/have not done, tell you about yourselves?

This clarity contributes to the development of their ability to listen to each other, their attempt to understand one other and create a supportive, encouraging environment, all this in order to help their child thrive.

### **Case Study**

Ada was a three month–old baby when her parents noticed she was unresponsive. Ada had been seen by different pediatricians and professionals. Each of them could see that Ada was not developing well; she never cried (sign no. 1), there was no babbling (sign no. 4), she had no facial expression, made no eye contact (sign no. 6) her motor development was very poor (sign no. 7). Some of the pediatricians said that the mother was hysterical, and others said they should wait another six months and see what happens.

When Ada was five months old, her parents approached the Mifne clinic for treatment.

Ada was the youngest child ever treated at the Mifne Center. She underwent two weeks of intensive sensory and emotional therapy. Ada was treated during all her waking hours, with the family taking an active part in the therapy and receiving an enormous amount of guidance.

### Family Background

Vera (28), Simon (32), their daughters Bonnie, aged five, and Ada, five months-old, were treated intensively at the Mifne Center for a period of two weeks.

#### *Vera – the mother*

Vera is the second child in a family of five (three girls and two boys). Her father was a Holocaust survivor from Romania; her mother is Hungarian. Having lost his first wife and five children in the Holocaust, the father made the decision to bring five more children into the world and to name them after the five who perished. Vera is one of them. Her parents immigrated to Israel after World War II. Their difficult relationship had an effect on Vera, who maintained that having a father who was a

Holocaust survivor made a significant difference to the atmosphere she absorbed in her parents' home (the father spoke about "the Holocaust" but never related to anything pertaining to his personal experiences). Her father's illness and death (from a brain tumor) was an extremely painful period for her, and she was intensely affected by his loss. She devoted much of her time to taking care of him while pregnant with her elder daughter Bonnie, and during the first year of her life. At the same time, she had underlying guilt feelings and a sense of helplessness because of what she considered was her limited ability to help him and offer him emotional support. Her negative relationship with her mother was fraught with tension.

### *Simon – The Father*

Simon's father, Romanian in origin, was brought up in Israel. His mother was born in a kibbutz. He is the middle of three sons.

The couple met in the town where Vera was living, and had been living there ever since their marriage of seven years standing. They gave the impression of having a positive relationship; they were open with one another and had a great deal of common understanding, with a certain measure of devotion and mutual dependence. Simon had the tendency to protect Vera from her acute concerns and anxieties. They made a joint decision to come to the Mifne Center for help with the problems resulting from Ada's condition, and were prepared to be full-time partners in the work with her, as well as in the family treatment.

The couple reported that the first pregnancy had been relatively easy, although her father's condition during this period took up much of Vera's time and was a cause of extreme concern to her. In addition to this was the worry about Vera's state of health, as she herself was suffering from thrombocytopenia. The second pregnancy was fraught with ambivalence and considerable tension between the couple. Vera maintained that she badly wanted another child, contrary to medical advice. At the same time she felt that "a time-bomb was ticking" during the course of the pregnancy. She had the feeling that she would die during the delivery, and leave Simon a widower.

Vera's anxieties were varied and expressed themselves in different areas. Apart from the issues mentioned previously, they were colored with a sense of a damaged self-image and self-imposed guilt as the person ostensibly responsible for Ada's condition. She assumed that the anxiety from which she had suffered during the pregnancy affected both its course and Ada's fetal development. She found herself unable to picture the baby to whom she would be giving birth. Her maternal concept was in direct opposition of how she perceived her own mother: she (Vera) would be a devoted mother, aware of her children's needs, happy at the prospect of their arrival, frank and honest with them and full of love. As a result, she expected that if she were to behave in this manner, Ada would react accordingly.

She started to blame herself both for her child's condition - especially when she became aware that Ada was spurning any contact with her - and for her own subsequent frustration. She therefore came to the conclusion that she was either a failure or not a good enough mother, or alternatively, that Ada had an incurable defect.

Vera wavered between the two options. By means of the first ("I am not a good mother"), Vera interpreted Ada's reactions to her with an underlying degree of self-destruction, i.e. Ada is unable to communicate with a mother who transmits to her negative messages such as "a mother suffering from depression", "a mother who is constantly pressurizing", "a tense mother", "a mother lacking in self-confidence". The second possibility ("Ada has a defect") indicated that Ada might be "a retarded child", a child with a "physical defect", a child with autistic traits.

Although the second possibility released her somewhat from part of the responsibility for the actual situation, it still left her with guilt feelings for her part in creating the problem. Wavering between the two possibilities removed the secure base from which she could choose the correct behavior to use both towards herself and towards Ada. The fear of approaching Ada who "rejected" her, and mainly because of the tension present in every situation involving contact with her, was also indicated in the way she physically held her. Her anxieties occasionally reached a point when they became somatic ("pressure and pain in the upper chest") with evidence of great stress.

Simon had an important role to play in the family in general, and between Ada and Vera in particular. He perceived Vera's anxieties intuitively. His role was to be a calming influence and a mediator. Sometimes he protected Vera with loving intentions, thus "releasing" her, as it were, from coping with those difficult situations that could be challenging and could ultimately lead to positive and liberating experiences where the bond between her and Ada is concerned.

It was interesting to note that, all this notwithstanding, Bonnie was developing nicely. She was not a source of tension and the bond between her and her parents appeared satisfactory.

Emphasis was placed on cultivating behavior patterns between Ada and the parents during the course of the "Mifne" treatment. As previously described, Vera and Simon were given guidance how to develop basic habits that would build up the relationship between them and Ada. This was done by consistently observing their behavior, offering pointers for change and giving feedback. They were encouraged to talk about their feelings during the exercises, to examine them, to focus on success and to make their own choice for change. During the course of a week, a significant amount of progress was achieved in

the capability for mutual bonding between Ada and her parents, and there was a noticeable improvement between her and Vera. At the point when they managed to break the “vicious” circle of “closing up, frustration, anxiety, self-blame, blaming others – and closing up again”, an emotional relaxation was noticeable (a mellowing of body language), and there were many moments of pleasure. Vera’s relative progress enabled Simon to give her more space, which increased her ability to face her maternal challenges. Nonetheless, his role as supporter and the person who was helping her overcome her anxieties remained significant, and probably will continue as such until Vera manages to receive support from other sources, such as individual therapy.

### *Ada*

Ada was brought to the therapeutic Center when she was five months old. She used to be an "easy baby"... She had no eye contact, she was unresponsive to any voice, did not turn her head. She neither smiled nor cried. Her motor development was very poor. Ada was treated at the Center for two weeks, twelve hours a day, including her rest periods. The parents were shown how they could communicate physically with their baby. The therapists used massage, movement and hydrotherapy for the development of her body experience. On the second day, as the therapist was trying to roll her over, Ada cried for the first time. On the third day she began showing some interest and looked directly at the therapist. During the first five days of treatment, the mother gradually relaxed and opened up to various stimuli which brought pleasure to both her and her baby. Ada began to react to facial stimuli and discovered her mother’s face. On the seventh day, after many attempts, Ada was willing to be spoon-fed and began to babble for the first time. Two days later, as a therapist was attracting her attention in the mirror, the mother entered the room and the baby became completely focused on her.

The parents were offered the following recommendations:

1. Vera should be allowed to confront her anxieties and process them by means of supportive individual therapy. Vera needs to have her fears justified, as long as they are bound up with the reality of her state of motherhood and Ada's condition. This way she will be able to face them and succeed in coping with aspects of acute anxiety.
2. Simon should participate in the therapeutic process as much as necessary to clarify his role and the part he plays in coping with Vera's anxieties, in order to process his own fears and lighten the heavy load on his shoulders.
3. Bonnie's place within the family should be firmly established, in order to ensure the continuation of her normal development.

4. Time should be made for consistent and ongoing practice, as this will be beneficial for the development of additional communication skills. These should be of mutual benefit (positive reinforcement) for the entire family.

5. As the family lives far from the Center, they may call any time for consultation. One of the Mifne therapists should see Ada every three months.

## **Results**

Ada was treated at home for a period of a year by her parents and one therapist.

At two years old she began to attend kindergarten with her peer group.

At five years old, Ada is functioning well above her peer group in all spheres of development, and she is very attached to her parents and sister.

## **Discussion**

The question is often asked: what would have happened to Ada had she not undergone that very early treatment. This question, naturally, cannot be answered. While reviewing previous video tapes of one hundred children over the last decade who were diagnosed with the autism spectrum at the age of two or three years, there were some indications pointing to early signs of attachment disorders, which gradually developed into the autism spectrum. This is why the term Pre-Autism is used. As a baby progresses towards the end of his first year, he develops more skills in all areas of functioning - motor, cognitive and social. This is a crucial period of time which emphasizes the gap between the normal and the abnormal development process. This might be one explanation for the minor indications during the first year of life. And thus, when parents do notice that something is wrong with their baby, they lose valuable time, either owing to their own difficulty in recognizing that there is a problem, or because of the lengthy procedures that many professionals take to follow up the baby's development. It is also interesting to note that babies whose parents came to the clinic at their own initiative, and underwent a therapeutic process, achieved better results than parents who were influenced by a third party, such as grandparents or pediatricians. Much thought has been given to "how not to cause panic among parents". Yet at the same time, the level of awareness must be increased.

Only very few children had not shown any early signs during their first year of life in the video tapes taken consistently by their parents. It is important to note that some of the video tapes were taken with large gaps between time periods. These cases should be studied further.

## **Conclusions**

Following the treatment of infants who showed early signs of pre-autism, and the rapid changes they underwent, it is clear that we must reach the stage where the early signs that could develop into autism are recognizable. The basic assumption leads to the conclusion that if babies were diagnosed and treated from early infancy, the development of autism might well be prevented in many cases. There is a reasonable basis to assume that this awareness can save many children in the future from being labeled with a developmental disorder on the autism spectrum.

The Mifne Center established a pioneer project in collaboration with the Child Psychiatry Unit of the Sourasky Medical Center in Tel-Aviv. The unit provides a novel service for the early detection and diagnosis of attachment disorders in infants from three to twelve months old, aimed to promote awareness of the importance of early diagnosis and treatment.

At the first half year since the diagnosis unit was established (2004), they used to see about two infants weekly. During the second half-year, they saw about four infants each week. The number of infants brought for diagnosis is increasing consistently. Those who show clear signs according to the ESPASI are referred for intensive treatment. All the infants seen at the unit enter the follow-up process until the age of three.

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