

Autistic Defenses and the Impairment of Cognitive Development

by

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Abstract

In this paper we suggest that unbearable early life experiences that force the infant to use autistic defences often constitutes a significant factor leading to cognitive impairment. These autistic defences are self generated (sensory) soothing devices that shut out consciousness of the world and foreclose the need to relate to anyone or anything that is not under the complete control of the subject. Two clinical examples are given from opposite ends of a continuum of patients with varying degrees of cognitive impairment.

Key words

Autism, Sensory defenses, Attention Deficit, Cognitive disabilities

Introduction

The impetus to write this paper came from our work with a group of patients who were self referred for what they had diagnosed in themselves as Attention Deficit Disorder. All but one of them had seen special shows on television on adult ADD or had read the recent best seller Driven to Distraction (Hallowell and Ratey, 1994), a book on ADD. The psychiatric interview is now considered by most experts to be the most accurate tool in diagnosing ADD and we concluded that these patients had the characteristic difficulties with attention. They also met the

criteria for ADD offered by Hallowell and Ratey. Our work with these patients led us to develop a theoretical construct to help us think about them and, ultimately, to conclude that some of their cognitive problems were at least in part caused by excessive reliance upon autistic defenses. We will give examples of how this group of patients suffer from an exaggerated dependence on autistic (sensory dominated) states of consciousness that produce a variety of symptoms including cognitive impairments. More simply stated, the patient persistently relies on his or her own generation of a sensory shape e.g. repeating the same song or phrase in one's mind over and over, or endlessly imaging geometric shapes, repeating rhythmic movements for hours (as in lap swimming or riding a stationary bicycle). This rhythmic repetitive sensory experience has the effect of managing the background anxiety with the mental equivalent of white sound (a sensory-filled consciousness that blocks out the environment).

It must be clearly understood that autistic defenses are a normal part of our repertoire of methods of survival and when used from time to time are protective of our sanity. We are focusing this discussion on those persons who have developed hypertrophied reliance upon autistic defenses and have thereby cut themselves off from a conscious participation in their own inner life and the life around them.

Attention deficit disorder, pervasive developmental disorder, minimal brain dysfunction, schizophrenia and mild retardation are some of the neuropsychiatric labels that had been previously given to our patients. There were dramatic differences in degree of impairment and a bewildering mixture of comorbidities to sort out. Some of the patients had seizures. Attempting to sort through the mixture of neurologic and psychiatric, soft and hard, vague and clear symptoms that these patients present is truly a challenge. Since these symptoms appear to arise from a complex interplay of body and mind, these patients tend to present a misleading and

confusing picture that causes them to fall between the slats of psychiatry and neurology. More often than not the patient is managed by a neurologist. The pediatrician, psychiatrist, internist and educator are also a part of the lattice. With this falling into no man's land (or more accurately, everyman's land) the patient often goes for years without treatment for the actual illness from which he is suffering or when treated is abandoned after years of treatment failure.

This collection of people, while having some cognitive difficulties in common, may not appear to be alike in many other ways. However, when they are listened to with the knowledge of a group of mental functions called autistic defenses, a remarkable similarity among this group of patients becomes recognizable and successful treatment is often possible. This paper attempts to reintroduce psychiatry into the treatment of these patients. When the fruits of the past thirty years of psychiatric and psychoanalytic research and practice are brought to bear on these cognitive difficulties there are new treatment possibilities opened for some of these patients.

A Theory of the Genesis of Some Not So Clearly Understood Neuropsychiatric Disorders.

We suggest that the patients in our group evidence varying degrees of autistic encapsulation which has contributed to the impairment of their mental and physical development. In this section we will introduce the background theory and concepts upon which our proposal is founded. This will be followed by a discussion of our clinical material. Our understanding of these patients is made possible by the combined theoretical and clinical contributions of several workers over several decades. The main influence on our thinking comes from Esther Bick, Eugenio and Renata Gaddini, James Grotstein, Margaret Mahler, Thomas Ogden and Frances Tustin, who have pioneered what has become the contemporary

analytic understanding of autistic anxiety and defenses as well as principles of technique for the treatment of autistic anxiety in both the severely disturbed and the higher functioning patient.

Autistic Contiguous Anxiety

Ogden (1989a) has described a mode of generating human experience which he calls the Autistic-Contiguous Mode. In elaborating on the nature of experience in this mode, he discusses two of Tustin's concepts in a way that brings the reader in touch with the state of primitive consciousness that is at the heart of this paper. I will quote him at length:

"Tustin (1980, 1984) has described two types of experience with objects that constitute important means of ordering and defining experience in the autistic-contiguous position. (These means of ordering and delineating experience are secondarily enlisted in the construction of psychological defense.) The first of these forms of relatedness to objects (which again only an outside observer would recognize as a relationship to an external object) is the creation of 'autistic shapes' (Tustin, 1984). Shapes generated in an autistic-contiguous mode must be distinguished from what we ordinarily think of as the shape of an object. These early shapes arise from the experience of soft touching of surfaces, which makes a sensory impression. The experience of shape in an autistic-contiguous mode does not involve the conception of the 'objectness' or 'thingness' of that which is being felt... For the infant, the objects generating shapes in an autistic-contiguous mode include the soft parts of his own body and the body of the mother as well as the soft bodily substances (including saliva, urine, and feces)... The second form of very early definition of sensory experience described by Tustin (1980), the experience of 'autistic objects', stands in marked contrast to the experience of autistic shapes. An autistic object is the experience of a hard, angular sensory surface that is created when an object is pressed hard against the infant's skin. In this form of experience, the individual experiences his surface (which in a sense is all there is of him) as a hard crust or armor that protects him against unspeakable dangers that only later will be given names. An autistic object is a safety-generating sensory impression of edgedness that defines, delineates, and protects one's otherwise exposed and vulnerable surface." pp 54-56

Anxiety of an autistic contiguous sort is experienced as physical or psychological disintegration of the subject; of being or becoming an amorphous shapeless sac. Ogden suggests that "formless dread might better reflect the nature of anxiety in the autistic-contiguous mode since the experience of shapes, rhythms, and patterns are the only 'names' that exist in this mode." (Ogden, 1989a p39) Any trauma, real or imagined, elicits images of disintegration, e.g. the feelings of leaking down the drain while showering. Others may fear that they will break if

they move fast. Still others are so sensitive to not having adequate “skin” that someone putting an object in the “wrong” place will produce a terrifying experience of complete loss of control of their inner world. This is because the objects in the environment feel as if they are a part of the subject and need to be omnipotently controlled by the subject. It is our opinion that when autistic-contiguous anxiety is the dominant experience, the associated compromised relatedness to the outside world leads to a myriad of symptoms including cognitive impairments. To a person in such a fragile state of existence, learning itself is a catastrophic event to the internal order of things since it introduces a change of one’s internal state which the individual feels must be kept perfectly constant.^[1]

The Formation of Skin and the Good Enough Mother

Esther Bick (1968, 1984) has discussed the way in which the infant makes use of his or her skin as a perimeter for the experience of self, a defining boundary for “the place where we live” (Winnicott, 1971). She underscored that the infant’s development of its own skin perimeter depends on the presence of a “good enough mother” (Winnicott, 1956). The ongoing holding by a healthy mother functions as a delimiting sensory surface and when incorporated by the infant as a “first skin” becomes the bedrock of a bounded sense of self. Bick elaborates on the pathological “second skin” formation that occurs in the absence of good enough mothering. “This faulty skin-formation produces a general fragility in later integration and organizations. It manifests itself in states of unintegration as distinct from regression involving the most basic types of partial or total unintegration of body, posture, motility, and corresponding functions of

^[1]It should be emphasized that these anxieties are often not consciously experienced. Instead, they are experienced as disturbances of bodily functions or coordination of those functions. For example, the somatic manifestations of this anxiety include disturbances of psychomuscular coordination so basic that a patient may be unable to walk across a flat surface at his normal pace or put on his jacket without becoming hopelessly entangled in the sleeves.

the mind, particularly communication. The ‘second skin’ phenomenon which replaces first skin interaction, manifests itself as either partial or total type of muscular shell or a corresponding verbal muscularity.” (Bick, 1968, p. 486)

Autistic Defenses

We would like to introduce an example of a severe autistic syndrome that is paradigmatic for the autistic defenses that will be discussed. In 1959, Eugenio and Renata Gaddini described a rare clinical condition they called “rumination” ^[2](also known as *mercysm*); a frequently fatal condition usually brought on by severe object loss in childhood. In their study, children from 3 months to 8 months of age had been exposed to loss of parents, either through physical and/or emotional separation (e.g. death of father followed by depression in the mother). The children became unresponsive to their environment and began to regurgitate their food by stimulating their hard palate with their thumb, when the food returned to their mouth they evidenced an “ecstatic” appearance on their face. The food would then be reswallowed and the process would be repeated over and over. Since the children refused food other than that which was being cyclically regurgitated and reswallowed, there was very little nutriment available to the body and so the children frequently went on to die of malnutrition. Ogden (1989a p. 61) postulated that the feeling created in the mouth by the swirling of the regurgitated food is an example of an autistic shape which serves as a “substitute for the mother, thus transforming the feeding experience from an avenue toward increasingly mature object relatedness, into a pathway leading to objectless ‘self-sufficiency’ (in which there is no self).” The Gaddinis’ found that only with an aggressive team of active caretakers in a hospital setting

^[2]This work is also described in detail by E. Gaddini in his paper “On Imitation”.

was it possible to reverse the almost complete disconnection from the outside world and help the child return to a life that included awareness of and interaction with actual external objects.

Tustin (1990), in describing the manifestations of autistic encapsulation, makes a distinction dividing autism into two varieties, psychological and neurological: “One problem in understanding these patients is that autism that arises from emotional disturbance may manifest itself similarly to that which arises from neurological deficits.” (p. 10) “The early reliance on bodily sensations (rocking, spinning, stroking) is a protective defence, furthering their encapsulation and idiosyncratic behavior. These behaviors are not shared with others and begin to form a fortress from which the patient feels there is no safe escape. This ‘autogenerated encapsulation’ is a defence that is unique to the autistic spectrum.” (p.17) “By becoming so encapsulated and focusing on their own sensations, the patient is unable to take note of sensations that can lead to a more normal interaction with the environment. Autism is a warped exaggeration of a psychochemical, neuro-mental reaction that is an innate protective measure against the trauma of bodily hurt, either illusory or actual...it arises from an over-reactive and aberrant use of normal processes...it is a rigid overdevelopment of the normal processes of shutting out of one's mind those affairs that cannot be handled at the moment. Encapsulation, engendered by idiosyncratic, stereotyped, and manipulative activities has shut out awareness in a rigid automatic sort of way" (p. 43). We maintain that whether the autistic symptoms are neurologic or psychologic in origin the patient speaks of them in the same language and each point of view has its own paradigmatic understanding. This writing is an attempt to move the two closer.

Clinical severity of autistic impairment is quite varied. At one end of the spectrum is the “early infantile autism” described by Leo Kanner (1944) where the child is in a

world that is impenetrable. Others (S. Klein, 1980; Tustin, 1984, 1990; Ogden, 1989a) have pointed out that there are also milder forms of autism present in children and adults. In all of these patients sensory objects and shapes are used as substitutes for environmental (maternal) needs.

Autistic Shapes

Autistic shapes are experiences of softness that serve as a skin for an individual whose anxiety centers on the fear of falling or leaking into “shapeless unbounded space” (Ogden, 1989a p. 68). Another important function of the sensory shape is to generate a sense of soft encapsulation comparable to being wrapped in a palpable fog that serves to keep outside objects from penetrating whatever rudimentary sense of boundedness the individual has achieved. The following are examples of sensory shapes regularly encountered in everyday life: Rocking, touching of walls as the subject moves through a room, being glued to a television screen or computer screen, the repetitive actions of sports e.g. throwing or kicking a ball over and over, continued practice of a single bar of music, continued talking (thereby creating a zone of noise around the subject), creating a zone of the subject’s own odor as a result of failure to bath. A sensory movement could be substituted in part with a repetitive mental act such as counting or imagining geometric shapes.

“Bearable vs. Unbearable” Frustration

Symbols are the substitute for the thing itself and are the medium in which thinking is performed. Normal development of a symbolic world is dependent on the child’s gradually being deprived of the mother (breast) in the process of a bearable weaning. The “good enough mother” has a native sense of gradual withdrawal from a state of ongoing moment by moment

preoccupation with the infant (Winnicott, 1956). With the introduction of well-dosed frustration, the child will be provided the necessary experiences of separateness that give rise to the experience of boundedness and the elaboration of symbolic capacities that are necessary to live apart from mother.

CLINICAL EXAMPLES

The purpose of the clinical presentations that follow is not to offer a full history of the development of the patient's symptomatology; instead, we will illustrate the kind of language that our patients used in talking about themselves and their difficulties.

Clinical summary I

The following clinical material is from the first several interviews with a very high functioning professional who gives the appearance of being well and happy to everyone but himself and his wife, whom he says angrily described him as a "wall of silence who locks himself in the bathroom. Not alive." This patient provides a verbal narrative of what it is like to exist with faulty boundary formation and the need for second skins. He is in continuous dread of physically disintegrating.

Mr. A, a 38 yr. old attorney, phoned for an appointment after his wife read to him several lists of symptoms of ADD given in the recent book Driven to Distraction (Hallowell and Ratey, 1994). The patient began by telling me he had ADD because he had nearly 100% of the items listed in the book. He was interested in trying Ritalin but added, almost as an afterthought, that he had some minor concerns about some strange feelings he gets from time to time. He said he

often has a “desire to isolate myself socially which may be costing me friends and the goodwill of my wife.”

While in law school, Mr. A had seen a neurologist and several psychiatrists for what was described by him as an undiagnosed psychiatric illness which prompted him to stop school for a semester. He just “did not want to be around anybody”. Numerous tranquilizers and antidepressants and psychotherapy were of no help. He stopped treatment, isolated himself from family and friends and after six months he felt well enough to return to school.

At the time of the first visit to my office he was started on Ritalin and, over several weeks, his dose was increased to 15mg TID (he had used amphetamines to help him read in law school). Mr. A could have been dismissed as someone requiring only medication. The fact that he is a high functioning well educated professional might have caused a consultant to think that Mr. A is not likely to suffer from an over reliance on primitive forms of defense. In order to identify such patients who might be helped by psychotherapeutic intervention, we will offer examples of the way Mr. A presented himself in his own words:

“In early childhood I had severe upper and lower respiratory problems. I was frequently rushed into the bathroom where mom would fill the room with steam to help relieve my coughing. Mom is not an alarmist, so it was a heavy message, as if she was saying ‘you might die.’ I got ear infections. I had bad allergies as a child as well as asthmatic attacks.” [The patient is introducing himself in physical sensation terms. What is important to him is not the particular type of illness but that he experienced anxiety in somatic form and that he is living in a world heavily loaded with somatic expression and somatic defense. This history of early childhood physical illness with the attendant interventions is characteristic of patients who have

overdeveloped bodily concerns and anxiety that at any moment they might break or even die, i.e. have high levels of autistic-contiguous anxiety and sensory (autistic) defenses.]

“I like white noise. It blocks out noxious stimuli. It was like a revelation, just running a fan is a life saver. I can't sleep without it. I used it all through law school for dorm noise. I could not read or concentrate without it. Mom says it's a reminder of the vaporizer from when I had croup. I loved it. I malingered to get her to stick it in my room.

Sometimes I think the bottom could drop out of my world at any moment. I don't think about it often but I have a background dread that something will go wrong at any moment.”
[The patient relies on sensory shapes to wrap him and protect him from uncontrollable anxiety].

“I convey a sedate laconic appearance but that's not how I feel. I have few objections to anything and take my lead from other people in most situations but, once the relationship gets defined, I get extremely upset when rules aren't followed. That is why I'm difficult to work for. There is no room for error when dealing with people's lives. I think things should be done my way.” [This demonstrates two of the most fundamental needs of an autistic person. First, they have little sense of personal desire and so they rely on imitation to manage socially (Taking the other persons lead). However, once the mold is cast they cannot adapt to even minor variations. Mr. A is describing the way he must have perfect control in order to experience safety.]

“I'd say I'm happy with my life--but not on a day to day basis. The nuts and bolts get under my skin. I feel like I have a crack in my windshield with the wind rushing in. I have trouble focusing on conversation at parties; or when something unexpected happens at work. [The degree to which he cannot focus or think in a crowd is so severe that his wife says (to her therapist) that she cannot get him to go to any social affairs.] I do fine when things are going smoothly. Large group parties are dreadful for me; I can't follow the conversations and I get

embarrassed. Small groups are easier.” [Here the patient talks about the cracked windshield of porous psychological skin which is so easily penetrated that he has to isolate himself from stimulus in order to not feel flooded, i.e., in order to be able to think.]

“I build a shell around myself. I always view life events as something to be gotten through. I want to get beyond things. I think its abnormal. Others look forward to things. I seek isolation. I seem to be always seeking a cocoon, a comfort zone. I look forward all day to getting back to my apartment. I'm in bed before 10 p.m. [The shell or cocoon is regularly mentioned by this group of patient. In this paragraph the patient also reports that his experience of life is exhausting and requires solitude and a great deal of sleep.]

“I have a memory--I am cold and just getting up. I am looking for clothing. I realize they were in the basement; I'd go down after the clothes; the furnace gave off great warmth; I'd go over and lean against it-near naked; I'd go into fugue-like state; There was darkness and warmth all around me.” [This experience of being wrapped in darkness and warmth can be understood as a sensory shape that enhanced the patient's sense of his perimeter.]

“I worry about being unfriendly towards my employees but, if I am friendly, I go over and over in my mind what might happen. I could lose control. As department head I have to maintain high standards. In the firm where I trained the department head was an SOB and the work was of the highest quality.” [The anxious dependency on imitation of the prior department head is a substitute for the development of his own way of relating to people. The ruminative worrying represents still another autistic self-soothing, this time in the form of repetitive mental activity (Ogden, 1989a p. 42).

Over the 7 month every other week treatment the patient has made remarkable progress. Mr. A reports to me that he has never felt so calm in his life as he does now. Socialization has

increased with, less fear of interaction with his employees, he has started a poker club and talks with the other department heads for the first time since joining the firm. He experiences “increased efficiency” at work and is able to leave his office door open while retaining his ability to work (demonstrating an increased capacity to focus without physical barriers to protect him). Mr. A is no longer sarcastic with dinner guests, has been more willing to go out to social gatherings, and has begun to read novels. The couples sex life has dramatically improved.

Of course it is impossible to isolate a single etiology for a group of symptoms and equally impossible to ascribe therapeutic gain to any single factor. Our intent in presenting the clinical material from the treatment of Mr. A is to suggest what seems to us to be an important correlation between the therapist’s awareness of a particular category of defenses and the therapeutic gains observed in relation to a form of cognitive impairment that had previously been refractory to neurologic, psychopharmacological and psychiatric treatment.

Clinical summary II

The second case is presented to illustrate how sensation-dominated defenses interfere with the development of cognitive capacities in a way that leads to more easily recognizable cognitive limitation that in the case of Mr. A. This patient was much more severely impaired and had never achieved any semblance of what her natural capacities would have lead one to predict.

I first saw Ms. C in consultation when she was 19, shortly after her father died. She had been treated unsuccessfully for three years with antidepressants and tranquilizers and was then referred to me for consultation. I did not have time to see the patient in ongoing treatment and

referred her for treatment of what I understood to be a reactive depression. She returned to my office when she was 35, divorced, unemployed and attempting to raise two daughters ages 6 and 9. This time I understood her symptomatology (the same as that which she presented 17 years earlier) as sequelae of early infancy trauma that had necessitated reliance on autistic defenses.

In the first week after her birth Ms. C underwent surgery, the first ever performed, for congenital absence of the upper part of her esophagus. She was fed through intra-thoracic tubes before and after surgery. During the months the patient spent in the hospital and then at home, her mother was afraid to touch her and carried her in a box. The patient's mother never adjusted to touching Ms. C except to occasionally slap her on the buttocks as a form of punishment as she grew older. For the succeeding five years the patient was taken to the doctor's office frequently by her aunt or father where a metal dilator was used to stretch her esophagus. Ms. C's mother refused to accompany the patient to the hospital because she could not bear to observe her daughter in such pain. During this procedure the patient was fully conscious and held down by the medical team. Ms. C never knew when she would be taken in for the dilatation procedure since she had no symptoms of blockage in the esophagus and was apparently being treated prophylactically. She begged to be told when the next treatment would occur but was lied to by her mother. She always experienced being taken by surprise and by force. Because of a heart abnormality and having only one kidney she was prohibited by her mother from running and from participating in general play with other children. The doctor did not advise any play limitations.

Ms. C was hyperactive in school and could not sit still or concentrate to read or write. Teachers were very interested in her but she was unable to respond to their encouragement. There were no findings by the pediatrician of evidence of early brain damage. Despite her

intelligence (she tested above average which was consistent with her teachers' impressions) she performed at a below average level. "It was hard to read books. I would have to read the same thing over and over. I wasn't paying attention. I would wander off."

Throughout her life she has felt clumsy. She was forever breaking things. During our first three years of working together, she was unemployed and slept every moment she could, getting up and coming out of her bedroom only when her children were home. She "behaved" like a mother when the children were home in order "to not have them worry about me and know what a weirdo their mother is." I understood this to reflect the fact that the presence of the children served to provide structure, shape and boundedness. When Ms. C was alone she could not create a shape for herself and depended on the sensation of the sheets and mattress against her skin to hold her together.

In the course of her therapy by means of her own memories, the historical data she gleaned from family members and the experience of the therapeutic transference relationship with me, I had an opportunity to learn about several of the ways in which she protected herself against the anxiety of being physically punctured. She needed a way to hold things in and to keep things out. She substituted for the missing maternal protective "envelope" (Brazelton, 1981) by utilizing other protective surfaces, which Bick calls second skin formations. This she did in an attempt to manage the fundamental anxiety of not having a sense of an adequate perimeter in which to live.

One way she accomplished this was by developing relationships with magical sensation experiences that were infinitely malleable, flexible and extensive. These sensation experiences had the psychological qualities of a large balloon that could never burst. These imagined

relationships served to supplement her own leaking porous perimeter. She describes one experience of this form of relatedness as follows:

“There is something that I can’t see. When I was little it was just something to hold. Squishy- pudgy. Something . A comforting thing. Breast comes to mind but that’s not right. If I could remember, it would be very clear. I want to know what it is. It was huge, not huge but big, something flexible. You could mold in any way, like gum. It would stay together, wouldn’t fall apart. It was like kneading dough. I’d love to know what that is. I keep seeing it, no, not seeing mostly feeling it. It’s just kind of there.” (It is interesting to note that the patient did not breast feed nor did her mother breast feed either of her brothers.)

I believe this “sensation thing” was not a memory of an experience with a breast; rather, it seems to be a description of a “relationship” with what Tustin (1984) has termed an “autistic shape.” This shape was used in place of a maternal provision which was unavailable. This magical comfort perfectly derived from this malleable shape is what I have in mind when I speak of the protective function of a relationship to an autistic shape.

A second way the patient had of defending against the experience of having a fractured porous perimeter was to make a specific kind of use of objects in the environment as a second skin. A form of imitation serves this function in that it feels as if the surface of the object has “rubbed off on oneself” and is now a part of one’s own surface. To quote Ms C., “When I was young I’d repeat exactly what my mother had said. As I grew up I got better at saying what my mother would say because I really didn’t have anything else to say. I just repeated what I knew she would say. I thought I was being grown up. But it wasn’t me. I was being a robot. Now I feel like I want to peel all my skin off like a sweater in order to see if there is anything of me

aside from her. My skin is my mother's ideas and words." The cognitive development of the patient remained at a virtual standstill; she simply "wore" her mother as a robe.

In what follows, the patient describes other ways in which she relies on imitation as a primitive form of internalization to give shape to herself and her mental contents. The presence of others holds her together in a rather literal way. The shape she adopts does not feel real to her but she is unable to function in the absence of the shaping function provided by other people and organizations such as jobs, family rules etc.

"I function the way I need to until no one is around and then I don't function at all. But when I'm around people I feel like a fake because it's not natural. I'm not natural. I feel like an expert at it, but there are times here that I don't feel like a fraud. Probably because I'm lying down, held together by the couch." This imitation is a substitute for a semi-permeable perimeter (analogous to a healthy cell membrane) which has the capacity to selectively take in and excrete (psychologically to learn and to express oneself).

It should be emphasized that the patient's descriptions of her experience are symbolic renderings of presymbolic experiences and as such are distortions of the original non-verbal, sensory experience. Putting these pre-verbal experiences into words (however imprecise) is the only way the patient has of making sense of herself (giving herself shape) and is therefore, powerfully therapeutic.

A third form of substitute for a healthy psychological perimeter evidenced by Ms. C. is the use of an autistic defense that functioned as a rigid psychic surface that served to protect her from being punctured. The following is a description in the patient's words of the experience of this autistic protective shell:

“I realized a lot [since the last session] but it is so horrible I don’t want to talk about it. You’re the only person I could share it with. It’s so weird. No matter what we talk about I was always getting the same vision of being in that hospital for those treatments and I couldn’t figure out what it was. And we talked about when did I die. When did I hide. It’s when I couldn’t stand it anymore. I became like a shell. I could see but couldn’t feel. I took all of my feelings and went into a corner and I let my mother’s ideas and thoughts fill the shell. I was so angry at them for making me feel I was bad for wiggling when I was being humiliated and feeling terrified of dying. The only way to let them think I was OK was to have them think it didn’t hurt and the only way I couldn’t hurt was not to be there.”

“Not being there” represents a form of consciousness which served to block out the experience of helplessness in the face of a terrifying external reality over which she had no influence whatever. Her skin remained hyposensitive to touch until several years into her analytic work, especially her mouth and sexual areas. She remained always on guard, expecting to be blind-sided with life threatening assault. She was hyperattentive to her environment without being able to differentiate between degrees of danger. Withdrawal from the world and sleep offered her a form of sanctuary. It seems that the anxiety associated with this constant vigil against (real or imagined) life-threatening assault required so much of her energy and attention that the reliance on this form of defense contributed to the development of a cognitive impairment (her inability to read, concentrate, listen, process information for communication).

At the termination of her therapy (eight years of three then two hours per week) the patient was free of psychosomatic symptoms. She no longer relied excessively on autistic defenses and was functioning well as the comptroller of a small manufacturing company. She could concentrate and handle difficult cognitive tasks even under significant stress. Ms. C had

developed an active social life and an interest in drawing. The patient's capacities for mature friendships and loving relationships with her daughters were greatly enhanced in the course of the therapy.

Discussion

In both clinical examples that we presented, emergency defensive measures helped the patient prevent psychological disintegration. However, the use of autistic defenses resulted in the formation of either a nonpermeable membrane (shell) or a membrane so porous that there was the psychic experience of raw skinlessness. Both Mr. A and Ms. C experienced difficulty learning (partaking of the world in a well-dosed way). Mr. A's capacity for learning was circumscribed and mechanical. He experienced no curiosity and was incapable of putting ideas together in his own way. As discussed, defensive reliance on sensory shapes involves the individual in a self-made world of magic and isolates the individual from consensual reality.

The dramatic difference between the first and second case has to do with the difference in degree of trauma in infancy as well as the fact that Mr. A. seems to have had a relatively healthy mother who actively nurtured and cared for him. Mr. A was able to develop a symbolic world whereas Ms.C was so compromised from the first minutes of life that she encased herself in a shell that was designed to extinguish her need for others. The quality of the cognitive impairment is what they have in common, not the degree of impairment. This derives from the commonality of the autistic defenses upon which they both relied.

These patients use the great majority of their psychic energy holding themselves together. They lag behind in developmental achievements e.g. they are usually delayed in walking, talking, and learning to dress themselves. They often lack spatial orientation e.g. they

commonly have difficulty driving a car or drawing a human form in an age appropriate way. They are often considered to be retarded because they cannot focus on the outside world sufficiently to learn and are often so clumsy as to be considered spastic. They are isolates and play alone, if they play at all. Even the healthiest of this group of patients does not enjoy crowds, parties, group sports or things that move fast which threaten their bodily integrity.

The generation of an autistic defensive organization is an ongoing process requiring considerable psychic energy. It could be said that these patients are too busy with this task to attend to the world, to learn or to think. From the point of view of the patient, the shell is both protective from outside hurt and keeps him or her from falling apart. The variability of stress at a given moment and the effectiveness of the defenses results in changing levels of functioning.

Ms. C. used pain as a “second skin” to connect the parts of her body. This derived from her first extrauterine experiences when she discovered herself through pain. Her sense of “me” was pain. Her boundaries were the limits of the experienced pain. On arising in the morning she shifted from the use of the feel of covers and mattress against her body, that helped provide a boundary for her during the night, to a reliance on the experience of pain as a skin surface and boundary. A very large percentage of the clinical material presented by these patients has to do with intactness or breaks in boundaries.

Treatment of the patient with autistic anxiety states must be specifically oriented to the particular form of autistic anxiety in evidence. We will more fully discuss the treatment of these patients in a separate paper. However, we will briefly comment on this topic here. A mainstay of the treatment of many of these patients has been the use of CNS stimulants such as Ritalin or Cylert. “Stimulants” have for decades been known to have an unexpectedly calming effect on this group of patients who seem overstimulated. Drugs and counseling about organization skills

alone may have some palliative effect in the very mild cases. It has been our experience that the majority of the patients in the group under discussion require psychotherapy that addresses the underlying anxiety. We have had considerable success in working with this group of patients when treatment is informed by a knowledge of autistic anxiety and defenses. The treatment situation must be well framed since boundary issues are the core of the pathology. The patient needs to see the same therapist each visit and must know his or her appointment times. There should be as few surprises as humanly possible. As the patient's autistic anxiety is understood and interpreted he or she feels held and contained. The sensory dimension of the patient's experience is consistently described in order to facilitate a move into a psychological world of symbols in which human dialog can take place. There is then an improvement in the individual's ability to use cognitive capacities as well as other stunted aspects of his or her personality.

Closing Remarks

In this paper we have described a group of patients who rely heavily on sensation-dominated defenses that seem to be important factors in the development of specific forms of cognitive impairment. In the past many of these patients were given diagnoses such as ADHD, pervasive developmental disorder, autistic disorder and mild mental retardation. In the absence of an understanding of autistic anxieties and defenses these patients have fallen between the slats of the medical and educational systems because they have been treated as suffering from either a neurologic disorder or psychiatric disorder. In this paper we are presenting a set of concepts that we find help to bridge the gap between psyche and soma thus allowing a fuller understanding of the nature of the cognitive deficit experienced by these patients which understanding will, hopefully contribute to the development of a more effective diagnostic and treatment approach.

We wish to emphasize that reliance on autistic defenses is being suggested as one important factor in the complex picture, but it is a factor which has not been explored to this point. This paper is being offered as an initial report not as a final conclusion.

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