ECRONICON OPEN ACCESS

EC PAEDIATRICS
Review Article

Myths and Realities about Psychoanalysis and Autism. The need for an integrated view from Psychoanalysis and Neurosciences

Ema Ponce de León Leiras*

Clinical Psychologist, PhD, Psychoanalyst, Psychoanalytic Association of Uruguay (Asociación Psicoanalítica del Uruguay-IPA), Montevideo, Uruguay

***Corresponding Author:** Ema Ponce de León Leiras, Clinical Psychologist, PhD, Psychoanalyst, Psychoanalytic Association of Uruguay (Asociación Psicoanalítica del Uruguay-IPA), Montevideo, Uruguay. **E-mail:** ema.pdl@gmail.com

Received: July 13, 2021; **Published:** August 28, 2021

Abstract

The present work discusses widely and with well-founded arguments, the current view of autism and the way that the neurosciences developments, added to prejudices, are used to disqualify psychoanalysis as a treatment in this field.

It analyzes five of the so-called "myths" in this article. They were originated in the historical oscillation of paradigms, that at one time emphasized the environment in the aetiology of autism and today emphasizes the biological, without true integration and without knowledge of the pyschoanalytical approach from an updated perspective.

The author supports the hypothesis that the common denominator as well as the heterogeneity of the DSM V category of ASDs is explained by various combinations of neurobiological vulnerability factors that prevent the adequate reception of responses from the environment and lead to a similar response modality, observed in the behavior and autistic maneuvers. She also maintains that psychoanalysis focuses on the subjectification process of the child with ASD, through a delicate process of construction of the psyche, which gives specificity and efficacy to the psychoanalytic treatment of autism.

Keywords: *Autism; Psychoanalysis; Child Psychotherapy; Neurosciences*

Introduction

This article is intended for physicians and psychologists who wish to have information on well-founded arguments to dismantle prejudices against the validity of psychoanalysis as a treatment for autism, as well as to encourage an integrated view of autism from different disciplines and the development of empirical research on the part of psychoanalysts. The paper´s objective is not to propose an extensive review of the findings of neurosciences and the therapeutic technique based on the contributions of psychoanalysis in this field, but stimulate interest in these issues.

[1]This work was published in French in La Psychiatrie de l'Enfant, 2020/2 (Vol. 63). A shorter version in Spanish was published in EIPEA, no. 5, November 2018.

Introduction to the current context of ASD and its diagnosis

Since Leo Kanner's first description of autism in 1943 to the Autism Spectrum Disorders (ASD) appearing in the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5), great changes have occurred in our understanding of autism. A growing amount of clinical and empirical research, treatment modalities, theories, etiological hypotheses, and detailed presentations of clinical cases, among others aspects, have given rise to different points of view - sometimes opposing points of view - and passionate discussions that generally do not lead to greater integration and collaboration in putting together the knowledge we have so far. Today, a certain disintegration and logic of exclusion exists between the different theories and findings on etiology, and prevention and therapeutic approaches, as well as a trend to uphold positions that disqualify diversity.

I believe quite the contrary, that the complexity and heterogeneity in the presentations of autism should lead to a greater willingness to examine, in the light of current findings and models, factors that have had and will have in the future therapeutic impact on the existing theoretical-clinical perspectives.

Advances in the field of neurosciences have made it possible to develop enough solid hypotheses about the neurobiological aspects involved, while recognizing that much is still unknown. There is consensus that it is a very early disorder, even though behavioral symptoms can appear or are detected later. There is also a tendency to focus on early signs, including prenatal ones, which may indicate the possibility of babies developing ASD.

Some argue that autism cannot be cured, but in many cases positive progress has been observed. Other researchers maintain that it is potentially reversible, and there is a percentage of patients that after their improvement will not be diagnosed with ASD [1].

In general terms, children with ASD present neurobiological and sensory alterations that mainly affect relationships and communication, producing loops of cause and effect between the difficulties in bonding and the neurobiological, psychological and affective development. They also tend to have repetitive behaviors, highly focused interests, and an atypical use of motor skills.

High stress and the difficulties of affective regulation can enhance the peculiar functions and behavior caused by the overwhelming experience of coming in contact with the demands of reality. All of this can occur in dissimilar combinations of varying intensity. They can present a unique profile and at the same time common manifestations.

Recognizing extensive heterogeneity in these pictures is a step forward, and it´s reflected in the new DSM-5 classification with the name of ASD, included in the broader category of Neurodevelopmental Disorders. This change aims to simplify the diagnosis of a wide variety of clinical pictures. Thus, a controversy arises about the advantages and risks of this new terminology, which replaces that of the DSM IV-TR, in which Autistic Disorder and Pervasive Developmental Disorders (PDD) were classified within the broader category of Disorders Usually First Diagnosed in Infancy Childhood or Adolescence.

The ASD category applies a dimensional and non-categorical criterion. It takes into account the intensity of the symptoms, classifying the disorders in increasing severity from the mildest to the most severe. However, the category´s breadth carries the risk of marking very diverse pictures with the term autistic, resulting in implications on the prognosis, the types of treatments implemented, and social stigmatization.

In child psychiatry, the child´s evolution provides a posteriori the confirmation of the initial diagnosis. Fortunately, the diagnosis usually leaves open questions that only evolution can answer, and this is something that, ethically, parents need to know.

Another possible objection is that this category favors the idea of an exponential increase in autism with a marked increase in prevalence, according to some studies. For some researchers such as Muratori [2], our increased knowledge of autism and diagnostic criteria, allows diagnosing cases that were not diagnosed previously, and this explains the increase in prevalence, which today is considered 1% of the general population.

Similarly, Hertz-Picciotto and Delwiche [3] believe that prevalence increased by 600% between 1990 and 2006 due to the increase in methods for early diagnosis.

On the other hand, according to Fisch [4], if diagnostic criteria are kept constant within a given period, and publications that use the same methodological instruments are grouped together, then statistical studies show stability in the prevalence of autism in the course of the last decades.

Another problem posed by the DSM for experienced clinicians is the elimination of childhood psychosis in these editions, being a source of difficulties and errors at the time of differential diagnosis - for example, between Early-Onset Childhood Psychosis and ASDs. Just as autism can be a risk factor for the later development of schizophrenia, there are also cases where signs of autism and psychosis appear together.

In view of the above clinical observations, Durban [5] proposes the existence of clinical pictures differentiated from the purely autistic spectrum, what he calls the autistic-psychotic spectrum, where autistic defenses are combined with psychotic anxieties. Often in the clinic the opening up of the autistic defensive organization produces the appearance of intense psychotic material, as well as constant fluctuations between different levels of anxieties.

As we can see, differential diagnosis is complex and, as often happens, manuals cannot replace the complex and comprehensive understanding of the clinician. In the case of relatively rapid and positive evolutions, the question arises as to whether it was a diagnosis of ASD or another condition, such as early environmental deprivation due to factors such as maternal depression, attachment difficulties, etc. which led to a disharmonious development combined with some autistic features or signs.

As a result of our clinical experience, I believe that there is an increase in clinical consultations of children from 2 and 3 years old with these characteristics. In these children, the response to early intervention is immediately noticeable. The presence of autistic signs in patients who do not meet all the criteria to be diagnosed with ASD, as well as the fact that a certain percentage of children who clearly have an early diagnosis of autism later don´t show symptoms [1], raises questions regarding the different possible pathways that lead to these symptomatic configurations, the complex biology-environment interrelation, the incidence of early interventions and parental attitude as an environmental factor in neurological development.

The environment is part of neurodevelopment, so the quality and characteristics of bonds affect in unison brain function and psychic constitution. Several research studies show how brain development is largely conditioned by the environment and affectional bonds [6-9].

It is important to point out that experts are beginning to approach autism from the perspective of "neurodiversity". They recognize that the use of sensorimotor abilities, and social and non-social relationships work differently, resulting in a diverse way of exploring and knowing the world [2]. This coincides with psychoanalytical theorists' descriptions of the diverse construction of the psyche in autism. For example, we cannot say that children with ASD have no interest in social aspects. Nevertheless, we can recognize that they have impairments - sometimes very extreme ones - fears, they do not know how to relate to others, or do so in peculiar ways. Alvarez, Reid and Hodges [10] propose the presence of a non-autistic part in children with autism, which is a way of acknowledging that the child with ASD has aspects and moments where they can connect, they can be affective, or enjoy with the other.

I believe that, currently, the increase in autistic traits in young children is also influenced by the presence of cultural and social factors, as well as living conditions that are contrary to the child´s needs of attachment, support, and containment. How the increase in sensory stimuli due to technology to which children are excessively exposed, often lacking the filter and the intermediation of the bond with parental figures, will impact neurobiological and psychic development is something that we cannot yet evaluate.

Aware of the difficulties that the name ASD can bring, we cannot avoid it today, knowing that, for the analyst, it will not imply losing the psychodynamic understanding of the singular case. Undoubtedly, the category of *class* is of a different order than that of subject, that of the particular and of contingency, present in the way of diagnosing in psychoanalysis and in this the neurosciences agree: each autistic person is unique. I recognize the advantage that the ASD category brings to the table by taking into account the commonalities as well as the heterogeneity of the ASD spectrum, where, fortunately, the severe autisms described by Kanner are a frank minority.

The main underlying theme of this study is the amount of what I call myths (I could also call them prejudices, statements based on partial knowledge or misinformation) widely held with regards to psychoanalysis and autism. These myths exist in both professional and social environments, resulting in ASD treatment proposals that exclude psychoanalysis.

One of the factors that contribute to these myths is the way that therapists choose theories to support their practice. They focus more on conjunctural and subjective processes, and less on conducting a systematic process of study and research of the different lines of thought. The result is a tendency to isolation and the lack of exchange between the different lines of thought.

In addition, psychoanalysis lacks a more convincing response through empirical research. There should be stronger presence of psychoanalysts and psychoanalytic therapists in areas where scientific collaboration with other lines of thought and disciplines has been successful.

Our aim is also to describe what is occurring with those that are approaching autism from a psychoanalytic perspective.

First myth: The biological etiology of autism would reject psychoanalytic treatment

The line of thought that focused on the psychogenic dimension is produced in the context of the Second World War. In this historical framework, Kanner [11] describes a syndrome in which the effects of environmental trauma were clearly observed in children abandoned and deprived of their bonds. At the end of the war, Spitz [12] described the clinical pictures of hospitalism, where environmental and affective deficits gave rise to a syndrome of global developmental delay, withdrawal, distress and then rejection of human contact, which became irreversible after the first five months of life.

Melanie Klein's theories on the early psyche with its paranoid and depressive anxieties and extremely crude fantasies, as well as Dick's (1930) analysis (perhaps today it could be diagnosed as an ASD), emerge in the interwar period.

It is very important to take into account the historical and cultural context in which the theories emerge, and to recognize how these theories worked and were effective under those circumstances, although we can explain them differently today. Awareness of the importance of the affective bond in development has been a major legacy for children's rights and upbringing, and its lasting social impact outweighs the effects of some erroneous hypotheses.

Today there is strong evidence of biological alterations in individuals with autism: genetic and epigenetic findings, neuroanatomical, neuromodulatory and neurotransmitter alterations, neural connectivity as well as sensory processing alterations, among others. They all are alterations that have an impact on early bonds. In addition, recent research goes beyond neurological features, for example identifying the relationship between toxic levels of stress and inflammatory processes that affect the autoimmune system [13].

This great diversity of findings supports the idea that there is no single and precise cause of ASD. There is no biological, genetic, or neurochemical marker. Instead, in each case there is a unique combination of multiple factors.

To explain the development of ASD, Singletary [14] proposes a comprehensive model, which involves the neurobiological and psychological elements in each child, as well as their interactions with caregivers. He argues that, due to neurobiological dysfunction, the child experiences a deprivation of parental stimuli (even when they are available), a feeling of isolation and fear. This leads to stress and the consequent "allostatic overload" at a psychic and physical level, amplifying biological vulnerabilities. For this author, psychoanalytic clinical work (in addition to being a research tool of the internal world of the child with ASD), manages to provide the child with an enriched environment, increasing the affective connection and giving meaning to his peculiar emotional experience, mainly the experiences of fear, loneliness, and not being understood. He illustrates this model with a clinical case.

However, the myth of psychoanalysis as opposed to biology continues to be spread in many areas, ignoring the current psychoanalytic scientific production and contrary to a much needed today comprehensive perspective. In the 80s, the topic was already being discussed in the United States, with the appearance of re-educational methods as opposed to psychoanalysis.

In recent years, the discussion has shifted to the political arena, where other interests and ground rules unrelated to science, intersect, and with initiatives to legislate on what type of treatment public health institutions should offer, eliminating the possibility of citizens to choose freely. In these projects, psychoanalysis is excluded from public services as a treatment for autism in different continents, including in countries such as Brazil[2] and France[3]. Psychoanalysts reacted and were able to block bills in both countries.

The analysis of these phenomena exceeds our objectives. However, I believe that the DSM-5 proposal of classifying ASD as Neurodevelopmental Disorders has an impact on all of this, that it is frequently associated with a scotomized view of neurodevelopment (derived from dualistic traditions and ancient paradigms that still permeate scientific thought) and not as a dynamic concept where biology and environment, body and psyche, go hand in hand. The conclusion stemming from this misconception that neurodevelopment is a predominantly biological process would be the exclusion of psychoanalysis as a treatment.

This classification also has the effect of transferring a growing group of patients to the area of neuropediatrics, in those countries in which neuropediatrics and childhood psychiatry are different specialties. In Italy, for example, both specialties are combined in neuropsychiatry. Neuropediatricians, who previously intervened to conduct the diagnosis, evaluating the neurological aspects of the child, have become those who diagnose and indicate treatments. The child psychiatrist, who in recent decades has received training in child development at the interface between the medical and the psychological, is often relegated. This shift is reflected in the fact that the psychological, relational, and subjective dimension is often dismissed in favor of a medical approach, with emphasis on deficit and handicap.

Child psychiatry and, in particular, psychodynamic child psychiatry, is gradually being left aside. Swiss psychiatrist and psychoanalyst Ansermet [15] says: "We can ask ourselves if autism, which was the center from which child psychiatry developed with Kanner, is not on the way today to become the field in which its disappearance is at stake" (p. 18). We believe the autism debate questions the relationship between psychoanalysis and the field of mental health in general, a topic which deserves to be developed further.

Ansermet [15] brings up an issue we should discuss with psychoanalysts regarding the alleged distance between psychoanalysis and the advances in neurosciences. The issue ignores neuropsychoanalysis, an important field developed in the last two decades by a signifi-

[2]https://psicanaliseautismoesaudepublica.wordpress.com/

[3]http://www.autistes-et-cliniciens.org/-Politique-de-l-autisme-

cant number of contemporary psychoanalysts, which explores the interface between neurobiological knowledge and psychoanalytic models of the human mind [7]. "The brain is the organ of the mind. If we want to fully understand mental life, we must integrate the findings of neurosciences at all levels of the mind"[4].

Ansermet and Magistretti [16] propose a point of intersection between heterogeneous phenomena, avoiding mutual exclusion or analogy. The intersection stems from neural plasticity that, being a universal mechanism, produces the singular, that is, the unique. Plasticity is lavish in consequences. The traces of experience modify the brain each time, once cataloged they re-associate producing a discontinuity in memory, everything is inscribed, preserved, and at the same time much can change.

For Ansermet the subject and the unconscious are the result of this discontinuity; biological determination is paradoxical, since the human is programmed not to be, to contingency, to receive the incidence of the Other. This line of thought leads us to agree that the current neurosciences do not move away from psychoanalysis, but rather that they come closer. They have in common the irreducibility of singularity, the unpredictability of the evolution of every subject.

Genetics itself is more and more the production of difference, of the heterogeneous, of the multiple. Ansermet and Giacobino [17] argue that there is no specific genetic constellation for autism; on the contrary, there are multiple and very often unique genetic determinations, specific to each case, and eventually limited to some individuals.

The results found point towards a multifactorial heterogeneity, without a cause-effect relationship, which can be summarized in the existence of a combination of multiple abnormal genetic events due to the convergence of dysfunctions. This, added to the enormous complexity of genetic research where the increasingly broader definition of autism moves away from the perspective of a genetic specificity, makes it all the more paradoxical.

Serge Lebovici (1915 - 2000) stated that psychoanalysis had no reason to fear the tremendous advances of the neurosciences. In fact, these advances and discoveries help us position ourselves as well as understanding many of the limitations we encounter in our practice. They also provide a means for treatment.

For example, research on alterations in sensory processing allows us to refine therapeutic strategies, in the same way as: "For a clinician, wondering about the moment when a stereotype occurs, seeing it as a defensive response of the autistic subject against the unbearable surroundings, is to give this subject a chance to detect unexpected differences in the repetition of the same thing and to take that sign as a possible lever in clinical work" [17]. That is, the biological data and the subjective signs, both pieces of information, are not mutually exclusive but rather increase our understanding of the phenomenon.

Before the DSM-5, the Neurodevelopmental Relationship and Communication Disorders classification appeared in the PDM [18], conceived by a working group of psychodynamically oriented psychiatrists. One of the members of the working group was Stanley Greenspan (1941-2010), a psychiatrist and psychoanalyst, who developed the Affect Diathesis Hypothesis about the genesis of autism that focused on constitutional alterations to connect affects with perceptions [19].

Later, the DSM-5 eliminated an important part of the original name, "of Relationship and Communication", that emphasizes a particularity. Some experts believe that by doing so, they overlook a key vector: the role of affect, as an expression of bonding, is inseparable from biological processes and global development.

[4]https://npsa-association.org.

In the neurosciences, Muratori [2] highlights the existence of a different brain function that manifests itself early on, and does not respond to social stimuli in the typical way. Thus, it interferes with early interactions and impedes the expected neurological and social development. His multiple research projects have focused on the early signs of autism, as a way to implement early interventions and achieve better outcomes [20-22]. For Muratori, it is important to observe early on whether the child shows such traits as greater interest in the human face than in objects, protodeclarative pointing, joint attention, anticipatory behaviors, social vocalization, and motor initiative. He highlights that the characteristics of motor skills are important aspects to observe in the early detection of autism.

My personal conclusion is that in order to explain the heterogeneity of autistic traits, I can hypothesize that the various combinations of neurobiological vulnerability factors lead to a similar response modality that can be clinically observed in autistic functions and maneuvers. The child perceives insufficient or overwhelming environmental stimuli and responds with behaviors such as disconnection from others and a preference for objects. The question remains open as to whether certain autistic behaviors are only determined by a diverse neurodevelopment, or whether defensive or compensatory reactions are being additionally structured on a second level.

We cannot ignore that the most primitive and extreme defensive resources of an organism to protect itself from adverse conditions are the behaviors of withdrawal and disconnection. Depending on the circumstances, sensory seeking or tonic recruitment appear to bring a feeling of bodily unity, vitality, and existence. Either aggressive, stereotyped behaviors or fixed interests appear in moments of frustration in the absence of adequate self-regulation in the face of the changing interpersonal reality. The structuring of defenses in the autistic child will eventually be part of the singular subjective psychic construction.

My hypothesis is that this sequence that develops in a singular way in a child with ASD, can be thought of as an effect of the traumatic shock between the individual's vulnerability and the external world (against which the child has no adequate resources), and not as a entity preformed in a univocal way from organic features.

Second myth: Psychoanalysis would blame parents for causing autism

Kanner [11] himself argued early on that autistic children seemed to be raised in emotional refrigerators. Evidently, he based his hypothesis on his observations of parenting and the difficulties that some parents had in relating to their autistic children, considering environmental factors as determining, following the prevailing paradigm of the time. Later on, he recognized, without disregarding the primary weight of the environment, that some children have a predisposition to autism due to genetic and congenital factors.

During this same time period, the experimental psychologist Bernard Rimland (1928 - 2006), whose son had been diagnosed with autism, published a book in which he encouraged researchers to consider how biological factors could influence human behavior. Bettleheim in his famous book "The Empty Fortress" (1967) followed Kanner's initial line of thought in the United States, relying on his personal experience in concentration camps where he lived with two autistic children. He studied thus the relationship between the autistic child´s environment and the concentration camps. In 1969, Kanner revised his initial position and argued in his speech at the *National Society for Autistic Children* that the condition of autism was innate.

The above description is important to understand how personal experiences and subjectivity can influence alleged scientific points of views, as well as the way in which these stories and their protagonists go on to feed myths that are coagulated in time, weighing more than the subsequent course of events.

Psychoanalysts' position with regard to the parents of children with ASD is far from blaming parenting and ignoring the etiological multifactoriality. All things considered, the need to take into account psychological and environmental aspects, to a lesser or greater extent depending on the case, cannot be ignored. It is essential to be able to work with the parents on their experiences (i.e. the resignifica-

tion of traumatic aspects of their stories around the birth of the child, the impact the child has on them and on the family environment, among others), because the parent´s anguish and difficulty to face the baby´s disconnection or the appearance of the child´s autistic traits is always there.

We must recognize that the environment´s ability to accommodate a child with ASD is unpredictable and variable; many develop behaviors highly adjusted to the child´s special needs, others may be themselves vulnerable, causing the feedback of circuits unfavorable for bonding, the environment, and the development of the family group.

The burden of biological and environmental factors, which organize a complex traumatic situation and alter neurological functioning and the possibility of psychic organization, according to Hoffman [23] is correlated (without attributing causality) with difficulties in the parent-child bond and the emergence of the psychic conflict when the level of evolution of the case allows it. In this sense, the psychoanalyst can not only guide and provide guidelines to the parents, but also work with them therapeutically to understand and influence the relationship between the child and his parents, giving rise to an intersubjectivity from which subjectivation becomes possible.

Third myth: The psychoanalytic method would not be applicable to autism

In the indication of treatment, the conditions that can be provided to address difficulties in the area of relationship and communication are more important than etiology. Undoubtedly, one of the ways to repair the failure in human subjectivity is the human bond, and psychoanalysis focuses on work with subjectivity and mental experience. There is consensus on the pertinence of psychotherapeutic intervention. From the bond with another, it can make significant changes, relying, as I have pointed out, on brain plasticity.

If we have in mind the classic child analysis that is based on playing and the interpretation of unconscious fantasies, then psychoanalytic work with ASD children lies elsewhere. When we work with children with ASD, we try to build a psyche, since in the most serious cases it is almost non-existent in its non-differentiation from the somatic dimension. Evolution shows that the achievement of this construction is possible, despite its difficulties.

There is no established method for the treatment of autism; however, there is an extensive bibliography on clinical work that is being done. As an example, I suggest an article of Ponce de León and Batistelli [24]. In these studies, there is a convergence in the use of resources adjusted to the characteristics of ASD. In all cases, the work focuses on the body, non-verbal communication, and sensoriality, features that are all crucial to the evolution of the child´s ability to represent. This means progressively building a bond and psychic experience in unison, creating resources and meanings to understand the external and internal world. The process implies a subjectivation process and access to intersubjectivity.

Today, psychoanalytic treatment is an essential part of an interdisciplinary approach, where other treatments and re-education are managed to overcome some of the difficulties that can arise from different and complementary points of view. Language treatments, pedagogical approaches, and other programs aimed at behavioral change are essential, but they do not attain the work with subjective suffering and the extreme anxieties of the child with ASD. The work with these patients must always include parents, either in their own setting and working in parallel with their child or in parent-child therapies, mother-child approaches, etc. All these alternatives depend on each individual and the preferences of each professional.

Despite the specificity of the psychoanalytic treatment of ASD, many of the elements that support this clinical practice are part of the theoretical-clinical background of the analysts:

- The session´s material is processed in the analyst´s mind and unconscious (i.e. Bion's *rêverie* function and Winnicott's holding and mirroring) since we cannot refer to an unconscious product of repression in these children, even though the concept of ASD

is so broad that it can include children with more evolved sectors of psychic functioning.

- Psychoanalytic theory will act as essential mental support against the risk of emptying and paralysis produced by autistic behaviors.

- A setting or analyzing device that is appropriate to these patients, which gradually provides conditions for connection with the patient and symbolization: continuity, security, and containment.

- Knowledge of the subtlety of the early processes of psychic constitution that allow exercising a function of para-excitation and careful modulation of affective contact, fundamental in these children who live in a threatening way with their libidinal drives requesting the bond and do not tolerate the excitement that causes the setting in motion of the instinctual life. Use of non-verbal or paraverbal interventions: the act, the gesture, the musicality of the voice.

- Anticipation of a subject from another subjectivity, that of the analyst who, with a unique way of thinking, of being, affectively and libidinally involved and of intervening, will enable the child to gradually take the place of subject.

- Tolerance to frustration, which involves decoding what seems to make no sense, seeking communication through the means proposed by the child, prevalence of the sensory, corporal and gestural registers, waiting for answers that do not arrive, and, even if they do, sustaining their symbolic function in the face of the puzzling and enigmatic experiences.

In view of the above, analysts do not work exclusively with the psychoanalytic method, but rather the psychoanalyst applies psychoanalytic psychotherapy or psychotherapeutic treatment of autism and uses the above elements.

Fourth myth: Psychoanalytic theory would be based on premises that do not apply to autism

On the theoretical level, the psychoanalysis of autism faces the challenge of defining the status of the psychic dimension, when the movements that attest psychic life are so precarious, so crude, sometimes just expressions of motor discharge, or primitive emotions. The work does not aim to understand the patient's unconscious although the analyst can get a glimpse of an ASD child´s psychic register from what seems to be traces of primitive inscriptions, or islands of representations linked to certain areas of experience.

If I take a look at some psychoanalytic metapsychological models in autism, I find a "negative" metapsychology. There is no other - it is excluded -, and there is no drive circuit, no signifying inscription, no conscious-unconscious division, or representational work. The voice is not articulated with the imagination and symbols that gives way to language, since the primordial articulation between body and language is nonexistent. Because there is no communicative language or symbolic play, the psychoanalytic method is limited to interpret what we observe.

However, based on the clinical work done with very young children and the observation of babies, psychoanalysis has an enormous amount of observations and research that has been enriched by authors from other disciplines, which have made it possible to elaborate different levels of theoretical hypotheses regarding the particular conditions of mental and behavioral functioning of children with ASD. They serve as a guide in clinical work and are in turn contrasted by their operational capacity.

There are psychoanalytic authors who are known for their work with primitive, autistic, or psychotic mental functions: Melanie Klein, Wilfred Bion, Margaret Mahler, Donald Winnicott, Esther Bick, Francis Tustin, Donald Meltzer and Piera Aulagnier, are some of the most relevant authors. Among the contemporary authors who have focused especially on autism, the works of Stanley Greenspan in United States, psychoanalysts Anne Alvarez, Stella Acquarone and Marie Rhode in United Kingdom, and psychoanalysts Geneviéve Haag, Didier Houzel, Myriam Boubli, Bernard Golse, Pierre Delion and Marie-Christine Laznik in France, stand out.

Without a doubt, theories regarding autism must be reviewed in the light of new findings in the neurosciences. If theories describe what is observed in the clinic using a conceptual framework and appropriate terminology, then those theories supported mainly by clinical observation will have greater validity in terms of the description of the mental functioning of the child with ASD and the flaws in their psychic constitution, but they will have less weight when they approach causal explanations.

The possibility of articulating these clinical observations with research on neurological and sensory alterations, peculiar cognitive functions, atypical behaviors, etc., is an important challenge for the future. Often the focus of attention is the same but the language is different, so the deconstruction and construction of new comprehensive models can be interesting.

Given the uniqueness of each case, the risk of theorization is generalization or establishing common models that have been successful in understanding some patients, but that cannot be applied to all cases. This risk is always there, and we must not forget the value of theories as imaginary and dynamic constructions without which we could not work, even though they are not always explanations of reality.

In view of the above, a theory is not a good starting point for discussions with other disciplines. I believe that the clinic is the common ground in which we can exchange viewpoints and show in a closer and more accessible way the psychoanalysts' way of thinking and intervening.

Between myth and reality? Psychoanalysis would not account for results through "evidence-based" research

This is a discussion that is taking place mostly within the field of psychoanalysis. Experts have opposing views as to the possibilities of conducting empirical research of the session materials and quantifying these fine clinical processes. The controversy between Green and Stern, and Green and Wallerstein [25] describes arguments on both sides.

André Green opposes all quantitative research and attempts of being objective. He argues that the clinical thinking characteristic of the analytic session is the only valid way of conducting research in psychoanalysis.

Daniel Stern (1934 - 2012), on the other hand, believes in the need for observational and empirical studies. He applies it to babies and their development, which provides knowledge of indirect relevance for psychoanalysis.

Even though it is difficult to reconcile the clinician's and the researcher's viewpoints in psychoanalysis, interesting results can be achieved. An example of this is Anne Alvarez and Anthony Lee's research [26] which is based on an intensive 4 year psychoanalytic psychotherapy of an autistic child that was filmed in its entirety in order to measure changes.

Undoubtedly, the internal epistemological debate has determined, and continues to determine, that the amount of psychoanalysts doing research is considerably lower than in the fields of cognitive-behavioral and cognitive neuropsychology.

Coriat initiated the evaluation of psychodynamic psychotherapy in 1917 and it has continued to develop in the last two decades. Nevertheless, there has been a growing number of empirical or clinical research and presentations on results and processes [27-29] and psychodynamic psychotherapy of children [30-32]. There are long-standing arguments on the part of psychoanalysts that defend the importance of empirical research to complement clinical research [33] as well as studies analyzing specific methodological aspects to consider when researching various psychodynamic approaches. Psychoanalysis is fundamentally a complex process. Multiple variables must be observed. The complexity of the problem should lead to collaboration between different researchers and clinicians [34].

However, it is important to note that solid knowledge is required to analyze the reliability of research in general, and very few clinicians have such knowledge. It is easy to conclude that the vast majority of psychotherapists of all tendencies defend their practice based on personal experience rather than knowledge of the different forms of psychotherapy; few do research and report results.

The American Psychological Association proposed the idea of implementing "evidence based therapies" borrowing the idea from the field of medicine. The idea was basically rejected in 2005 because it was inadequate and replaced with evidence-based practice.

Along these lines, some authors in the field of psychoanalysis [35] stress the importance of further developing the qualitative evaluation of clinical practice based on a psychoanalytic epistemology, and not on a purely medical model of quantitative evaluation. The "proof" stems from practices under natural conditions. Evidence-based studies benefit cognitive-behavioral therapies that evaluate results based on symptoms disappearing, rather than on interpersonal relationships or psychic and general functioning, which are far more difficult to evaluate.

All previous observations on psychoanalytic psychotherapy research in general are necessary to understand today's research on ASD patient treatments.

With regards to psychoanalytic clinical experience with autism, there is evaluation and transmission, and extensive bibliography on clinical cases, techniques, and characteristics of the processes. I can conclude that they are generally prolonged treatments, and that they produce significant transformations in several areas, depending on the case´s initial severity and the age when the treatment was initiated. In general, there is not a lot of rigorous and systematic research, however descriptions of some of the worthwhile studies follow.

Thurin, Thurin, Cohen, and Falissard's [36] research introduces the first results of a multicenter, process-outcome longitudinal study, exploring individual psychotherapies of autistic children conducted under natural conditions for one year. It uses intensive studies of 50 individual cases responding to the current criteria of evidence-based practice. Of these cases, 41 are of psychoanalytic reference, 5 cognitive-behavioral, 3 of psychomotor reference, and one refers to play therapy. The results show significant changes in several areas over the first year of treatment, taking into account the therapeutic setting, the therapist's adjustment to the child, and the work of symbolization.

I consider of interest the single case studies on the efficacy of psychoanalytic treatment in autism such as that of Vecchiato, Sacchi, Simonelli and Purgato [37], as well as the studies by Anne Brun, Lorin de Reure and Rabeyron for the evaluation of different devices of therapeutic mediation with autistic children [35].

These studies are accompanied by the creation of research instruments based on psychodynamic criteria. One of these tools is the Autism Psychodynamic Evaluation of Changes (APEC) by Haag et al[5]. The knowledge and use of this tool by analysts of children working with autism is of enormous interest and affirms psychoanalysis in the field of mental health.

In a similar way, a group of child analysts from psychoanalytic societies in Brazil called Autism Psychoanalytic Research Group (*Grupo de Pesquisa Psicanalítica em Autismo - GPPA*) has developed a Protocol for Psychoanalytic Research on Signs of Changes in Autism, called PRISMA [38], with a subsidy from the International Psychoanalytical Association, the group continues to work on the Protocol in order to reach the validation phase.

To further complicate the issue of the greater reliability of evidence-based studies and comparative advantage of cognitive-behavioral psychotherapies (CBT), Leichsenring and Steinert [39] have conducted an in-depth review of various aspects of these studies, questioning the preeminent status of CBT based on rigorous analysis of methodological criteria that are not followed in these research projects.

[5]The APEC is based on a scale developed by Haag et al. It was initially published in the International Journal of Psychoanalysis in 2005, then it has had a statistical validation from a clinical-biological research directed by Tordjamn in 2010; It has also been used in the Network for Research Projects Founded on Psychotherapeutic Practices (*Réseau de recherches fondées sur les pratiques psychothérapiques - RRFPP*) since 2008. The full scale and its background can be found at www.researchgate.com.

I advocate the importance of furthering research on psychoanalytic treatment results, However, the more we delve into the information that emerges from the research, the more aware we become of the increasing demands they entail.

The debate on the "Dodo Bird Verdict" refers to the idea that all psychotherapies obtain the same results. [40]. González-Blanch and Carral Fernández [41] argue in their convincing article that although there is reasonable evidence that psychotherapies work on a wide range of mental problems, many studies that support the efficacy of psychotherapies are subject to significant limitations, biases, and weaknesses. This also applies to research in neurosciences. Recent studies warn of different kinds of failures in much of the research on the biological causes of mental illnesses [42]. This leads us to another aspect that needs to be demystified: the field of empirical research does not have a less complex and clearer path than the laborious and always questioned exercise of our daily clinic. This is one of the many myths that come up in our search for certainties in the face of increased uncertainty in the destiny of our societies.

Conclusion

In conclusion, I would like to review the main points covered in this article, as well as to share some observations with regard to psychoanalysis in the current context of ASD treatments.

Regarding diagnosis, the consequences of the DSM-5 classification of Autism Spectrum Disorders (ASD) and the Neurodevelopmental Disorders classification were discussed. The study also points out that experts diagnosing ASD during childhood should be open to the possibility of eventually reformulating their diagnoses, and that the diagnosis can be confirmed only with evolution.

Regarding etiology, this study pointed out the importance of doing away with false oppositions: biology-environment, body-psyche, psychoanalysis-neuroscience, based on arguments and developments of contemporary researchers. I have shown how research in the field of genetics, in addition to being highly complex in its design, today holds a strong paradox insofar as it seeks the specificity of the autism gene starting from an increasingly broad definition of it. The only thing that can be said is that autism results from a unique multifactorial combination that varies in different types of cases. What emerges from current neurosciences is that we are programmed not to be programmed, that is, to receive the influence of the environment and intersubjectivity.

From this I conclude that we can refer to "autisms" of heterogeneous etiopathogenic configurations, where despite the evidence of neurobiological alterations that affect the interrelation with the environment, there is no "preformed" autism stemming from organic features as there is no biological marker defining it. Hence a highly individual profile is being developed in each case. I can say that ASDs account for a complex biological vulnerability, which prevents adequate reception of responses from the environment, and which makes it a frustrating and overwhelming element. The child cannot use the environment for his social-affective growth, with reinforces basic difficulties.

The indication of treatments should take into account that both the data from biology and the subjective signs must be taken into account together to increase the understanding of the phenomenon. It is not possible to think of helping a child with ASD to improve communication with others, without making communication and bonds the basis from which to work. Although biological changes are the backdrop, there is no biological cure on the current horizon. One of the undisputed ways to repair failures in the human constitution, what makes us subjects, is the human bond; and psychoanalysis has as its primary tool the establishment of a bond in which subjectivation becomes possible. In the case of autisms and ASD, it is not a matter of working on unconscious conflicts but of working on the delicate processes of the construction of the psyche. This gives specificity to the psychoanalytic treatment of these cases.

Cognitive-behavioral treatments (CBT) propose the modification of behaviors and cognitions through learning techniques. The goal in children with ASD is to teach adaptive habits, social and language skills, regulate overflows, etc. and provide guidelines for the family. They also have methods to address the different levels of learning that allow schooling. I believe in the usefulness of these approaches to improve adaptation to the environment, within the framework of interdisciplinary work, as long as it is carried out in such a way as to

avoid the risk of a conception based on training and the mechanical acquisition of expected behaviors, supported by the tendency of these children to automate behaviors. This modality is opposite to subjective appropriation, where the child, through a singular path, incorporates not only behaviors but ways of being, in order to be humanized, in order to become a special and unique person.

I do not ignore the importance of adaptation, as long as we avoid falling into "normotic" behavior (McDougall, 1978). For this reason, I support the possible complementarity of both treatments, relying precisely on their different approaches and as part of interdisciplinary strategies, fundamental for further advancement of these patients. Children with ASD are patients to be treated by an interdisciplinary team, given that they need various approaches to stimulate different areas of their development: speech therapy, psychomotor skills, psychotherapy, psychopedagogy, etc. Each case needs a carefully planned therapeutic strategy subject to review, where different interventions can be proposed simultaneously or sequentially, or creative proposals that combine different disciplines working simultaneously [43].

Regarding the contribution of research to determine the efficacy of psychotherapies, I believe it is necessary to draw on both empirical evaluations based on evidence and evaluations based on clinical practice, but not without warning about the need for specialized training to measure its complexity and draw valid conclusions.

Finally, as we have seen, the debate around the relevance of psychoanalytic treatment for autism is bringing to the discussion table the relationship between psychoanalysis and mental health, which is why it is an essential issue for those of us who know the benefits of psychoanalytic treatments for children with ASD and their families.

We must keep in mind that in our field the goal of clinical and empirical research is to provide answers to the subject and not to science. I maintain the hope that, in the future of scientific knowledge, a path will be built that moves away from the classifying effort and focuses on the forms of patient care, on refining strategies to address the uniqueness of human suffering.

Bibliography

1. Fein D., *et al*. "Optimal outcome in individuals with a history of autism". *Journal of Child Psychology and Psychiatry* 54.2 (2013): 195-205.

2. Muratori F. "Course "Autism Spectrum Disorders" organized by Organizado por Clínica del Niño-Harwood Care". Held in Montevideo, Uruguay (2018).

3. Hertz-Picciotto I and Delwiche L. "The risk in autism and the role of age at diagnosis". *Epidemiology* 20.1 (2009): 84-90.

4. Fisch GS. "Nosology and epidemiology in autism: classification counts". *American Journal of Medical Genetics Part C: Seminars in Medical Genetic* 160C.2 (2012): 91-103.

5. Durban J. "In the beginning was the world? The changing shape and use of interpretations in the analyses of children on the Autisto-Psychotic Spectrum, Sufrimiento Psíquico". Autismo e Relacoes Iniciais. Abordagem Psicanalitica. Conferencia llevada a cabo en la V Jornada de Autismo da SBPSP, San Paulo, Brasil (2018).

6. Gaugler T., *et al*. "Most genetic risk for autism resides with common variation". *Nature Genetics* 46.8 (2014): 881-885.

7. Solms M and y Turnbull O. "What is neuropsychoanalysis?" *Neuropsychoanalysis* 13.2 (2011): 133-145.

8. Damasio A. "Descartes Error: Emotion, Reason and the Human Brain". Avon Books: New York (1994).

9. Damasio A. "The Feeling of What Happens; Body and Emotion in the Making of Consciousness". London: Heinemann (1999).

10. Alvarez A., *et al*. "Autism and play-the work of the Tavistock autism workshop". *Child Language Teaching and Therapy* 15.1 (1999): 53-64.

11. Kanner L. "Autistic disturbances of affective contact". *Nervous Child* 2.3 (1943): 217-250.

12. Spitz RA. "Hospitalism: An inquiry into the genesis of psychiatric conditions in early childhood". *The Psychoanalytic Study of the Child* 1.1 (1945): 53-74.

13. Pramparo T., *et al*. "Prediction of autism by translation and immune/inflammation co-expressed genes in toddlers from pediatric community practices". *JAMA Psychiatry* 72.4 (2015): 386-394.

14. Singletary WM. "An integrative model of autism spectrum disorder. ASD as a neurobiological disorder of experienced environmemental deprivation, early life stress and allostatic overload". *Neuropsychoanalysis* 27.2 (2015): 81-119.

15. Ansermet F. "Irréductible singularité, En P. Sadoun (Edition.), Le spectre autistique trouble-t-il la raison de ceux qui l'approchent? (2016): 11-35.

16. Ansermet F and y Magistretti P. "A cada cual su cerebro. Plasticidad neuronal e inconsciente". Buenos Aires, Argentina: Katz (2006).

17. Ansermet F and Giacobino A. "Autisme. A chacun son génome.Navarin/Le Champ freudien". Paris, Francia: Navarin (2012).

18. PDM Task Force. "Psychodynamic Diagnostic Manual. Silver Spring, Estados Unidos: Alliance of Psychoanalytic Organizations (2006).

19. Greenspan S. "The affect diathesis hypothesis: The Role of Emotions in the Core Deficit in Autism and in the Development of Intelligence and Social Skills". *Journal of Developmental and Learning Disorders* 5.1 (2001): 1-44.

20. Muratori F and Maestro S. "Early signs of autism in the first year of life". *In Signs of Autism in Infants* (2018): 46-62.

21. Conti E., *et al*. "The first 1000 days of the autistic brain: a systematic review of diffusion imaging studies". *Frontiers in Human Neuroscience* 9 (2015):159.

22. Costanzo V., *et al*. "Early detection of autism spectrum disorders: from retrospective home video studies to prospective 'high risk'sibling studies". *Neuroscience and Biobehavioral Reviews* 55 (2015): 627-635.

23. Hoffman J. "Autisme et narration. Autisme: état des lieux et horizons. Sous la direction de Golse B. et Delion P., Edition. Erés, Ramonville Saint-Agne (2006).

24. Ponce de León Leiras E and Batistelli Viera F. "Reflexôes psicanalíticas sobre un caso como Trastorno do Espectro Autista (TEA)". *Estilos da Clínica* 19.2 (2014).

25. Sandler J., *et al*. "Psychoanalytic monographs Nº 5. Clinical and Observational Psychoanalytic Research: Roots of a Controversy". Londres, Inglaterra: Karnac (2000).

26. Alvarez A and Lee A. "Early forms of relatedness in autism. A longitudinal clinical and quantitative single case study". *Clinical Child Psychology and Psychiatry* 9 (2004): 499-518.

27. Leichsenring F and Rabung S. "Long-term psychodynamic psychotherapy in complex mental disorders: update of a meta-analysis". *The British Journal of Psychiatry: the Journal of Mental Science* 199.1 (2011): 15-22.

28. Levy R., *et al*. "Psychodynamic Psychotherapy Research-Evidence-Based Practice and Practice-Based Evidence". Londres, Inglaterra: Human Press (2012).

29. Luyten P., *et al*. "Handbook of Psychodynamic Approaches to Psychopthology". London: Guilford Press (2015).

30. Nemirovski J., *et al*. "Outcome of psychodynamic child psychotherapy in routine practice". *European Journal of Psychotherapy and Counselling* 16.3 (2014): 228-244.

31. AACAP Official Action. "Practice Parameter for Psychodinamic Psychotherapy with Children". *Journal of the American Academy of Child and Adolescent Psychiatry* 51.5 (2012): 591-557.

32. Steinert C., *et al*. "Psychodynamic Therapy: As Efficacious as Other Empirically Supported Treatments? A Meta-Analysis Testing Equivalence of Outcomes". *The American Journal of Psychiatry* 174 (2017): 943-953.

33. Fonagy P. "The effectiveness of psychodynamic psychotherapies: an update". *World Psychiatry* 14.2 (2015): 137-150.

34. Thurin JM. "Aspects métodologiques de l'approche psychodynamique (psychanalytique)". *Récupéré de* (2018).

35. Brun A., *et al*. "Evaluation clinique des psychothérapies psychanalytiques". Dispositifs individuels, groupaux et institutionnels, Paris: Dunod (2016).

36. Thurin JM., *et al*. "Approches psychothérapeutiques de l'autisme. Résultats préliminaires á partir de 50 études intensives de cas". *Neuropsychiatrie de l'Enfance et l'Adoloescence* 62.2 (2014): 102-118.

37. Vecchiato M., *et al*. "Evaluating the efficacy of psychodynamic treatment on a single case of autism. A qualitative research". *Psychotherapy: Psychopathology, Process and Outcome* 19.1 (2016): 49-57.

38. Lisondo A., *et al*. "Investigación psicoanalítica y cambios en el autismo: presentando el PRISMA". *Eipea* 3 (2017): 25-29.

39. Leichsenring F and Steinert, C. "Is Cognitive Behavioral Therapy the Gold Standard for Psychotherapy? The Need for Plurality in Treatment and Research". *JAMA: The Journal of the American Medical Association* 318.14 (2017): 1323-1324.

40. Rosenzweig S. "Some implicit common factors in diverse methods of psychotherapy: "At last the Dodo said, 'Everybody has won and all must have prizes". *American Journal of Orthopsychiatry* 6 (1936): 412-415.

41. González-Blanch C and y Carral-Fernández L. "Cage up dodo, please! the tale of all psychotherapies being equally effective". *Papeles del Psicólogo/Psychologist Papers* 38.2 (2017): 94-106.

42. Dumas-Mallet S., *et al*. "Scientific Uncertainty in the Press: How Newspapers Describe Initial Biomedical Findings". *Science Communication* 40.1 (2018): 124-141.

43. Ponce de León, E. "Una propuesta interdisciplinaria: psicoanálisis y psicomotricidad en una técnica conjunta para el tratamiento de niños". *Revista Uruguaya de Psicoanálisis* 96 (2002): 109-124.

Volume 10 Issue 9 September 2021