

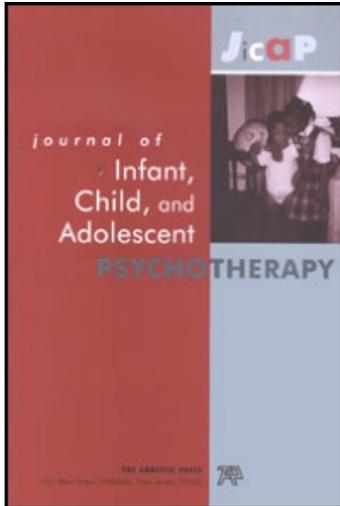
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Mentalizing the Unmentalizable: Parenting Children on the Spectrum

Arietta Slade, Ph.D.

This paper is aimed at exploring the idea that parents of children on the autistic spectrum must, throughout their child's development, contend with a particular and painful paradox unique to the neurobiology of autism. This is the paradox: For no reason other than the vagaries of biology, their child has come into the world with a fundamental disability in the capacity to develop relationships, a disability that will have devastating and pervasive consequences not only for the child, but for those who love and care for him as well. These difficulties stem from a neurobiologically based inability to process social information, such as facial expressions, affects, social cues, certain elements of language, and the like (Volkmar, 2007; Volkmar et al., 2004), which in turn profoundly limit the child's capacity to make sense of or even recognize his own or others' mental states, that is, to mentalize (for reviews, see Allen, Fonagy, and Bateman, 2008; Sharp, 2006).

From the parent's perspective, the unique constraints of the child's "mindblindedness" (Baron-Cohen, 1995) make him a most challenging and disorienting social partner, one who, at least until treatment has begun to take hold, brings few of the pleasures and rewards inherent in reciprocal interaction, and who, as a function of his difficulties meeting the mind of the other, elicits feelings that are at times frightening and nearly unbearable and that cannot be processed within the relationship itself. Yet, like all children, this child needs relationships to survive, on every level. But even more than most children, this child needs his parents, in particular, to initiate him into and guide him in the world of relationships and to remain stable regulators of his experience well into adulthood. Thus, the parents of children on the spectrum must not only make sense of what at first, second, and tenth glance seems incomprehensible, but they must also do so in the *absence* of the palpable pleasures of reciprocity and mutuality and in the presence of their own powerful and often disabling emotions. In other words, to connect with their child and help develop the relational and mentalizing capacities that are crucial to his adaptation, parents must *mentalize the unmentalizable*.

This mentalizing paradox is complex and multifaceted. Yet there are few parents of children on the spectrum who do not hope to and indeed succeed in embracing this challenge. Indeed, the more I have tried to think through and imagine the many complexities of parenting a child on the spectrum, the more I have come to appreciate the depth, breadth, and enormous complexity of this paradox, and the more I have come to appreciate the extraordinary courage of the legions of par-

ents for whom this paradox is a central fact of their daily life. Indeed, it speaks to the wonders of the human spirit and the resiliency of our evolutionarily selected drive to protect and nurture our young that so many parents of children on the spectrum do so much, and with such creativity, determination, and passion (see Crown, this issue; Kalmanson, this issue).

In the sections below, I will begin by summarizing some of the basic assumptions of mentalization theory as they pertain to attachment, socio-emotional development, and parenting. These will provide the background for delineating the contours of the mentalizing paradox that is the focus of this paper. Finally, I will argue that a key element of success in working with children on the spectrum and their parents will be to help parents manage this essential paradox, such that they are able to both recognize and give voice to its complexities without being defeated by it. To this end, clinicians must not only appreciate its breadth and depth, but they must also be willing and able to address its particular challenges in an ongoing way. As so beautifully exemplified by Crown (this issue), helping a parent find ways to manage the confusion and anguish that is intrinsic to living with these fundamental contradictions must be central in the mind of the clinician and will be essential to any effective treatment approach.

ATTACHMENT AND MENTALIZATION IN TYPICAL DEVELOPMENT

The human capacity to form relationships, to become attached, has been evolutionarily selected to ensure our survival. In nearly every respect, relationships are central to our humanity and to our feeling alive and in the world. From the perspective of contemporary psychoanalytic theory, the relationship is the birthplace of the self. That is, the fundamentals of the capacity to feel connected to and sustained by others, to experience oneself as safe and whole, to regulate affective experience, and to distinguish self from other emerge within the context of the child's primary relationships. In particular, they are dependent upon the parent's capacity for "emotional availability" (Mahler, Pine, and Bergman, 1975), "sensitive responsiveness" (Ainsworth et al., 1978), "attunement" (Stern, 1985), or, more generally, the provision of a "facilitating environment" (Winnicott, 1965) or "secure base" (Ainsworth et al., 1978).

The terms sensitivity, emotional availability, attunement, and the like all refer to the parent's capacity to make sense of the baby's experience and to respond to the child on the basis of this understanding. Fonagy and his colleagues have referred to this as the capacity to mentalize (Fonagy et al., 2002; Slade, 2005). The term mentalization (or reflective functioning) refers to the capacity to envision mental states in the self or other, to use an understanding of mental states—intentions, feelings, thoughts, desires, and beliefs—to make sense of, and even more important, to anticipate another's (or her own) actions. While all relationships depend to some extent upon the capacity to reflect upon one's own and others' mental states, the child in particular needs this from his parents. While most children are born with the tools they will need to ultimately develop the capacity to mentalize, early relationships create the opportunity for the child to learn about mental states and determine the depth to which the social environment can ultimately be processed (Fonagy et al., 2002). Thus, from the perspective of mentalization theory, it is the parent's capacity to "hold the child in mind," to understand the child's behavior in terms of his underlying feelings and intentions that will allow her to respond sensitively and contingently and that will promote affect regulation and integration in the child (Slade, 2005, 2007).

Mentalization and the Spectrum Disorders

Over the past 15 years, it has become clear that one of the defining characteristics of autistic spectrum disorders is an extreme and neurologically based deficit in mentalization, or what Baron-Cohen (1995) referred to as “mindblindedness,” a particular inability to make sense of or even recognize the mental states of others (for reviews, see Allen et al., 2008; Sharp, 2006). These deficits are reflected in many aspects of functioning, in particular the lack of preferential orientation to social stimuli, low levels of emotional engagement and responsiveness, failure to engage in and initiate joint activities, impaired language learning, poor performance in theory-of-mind tasks, lack of engagement in pretend play and imaginative activities, and deficient self-awareness (Allen et al., 2008). As a function of this deficit, children on the spectrum are to a large extent unrewarded by the usual pleasures of reciprocity and mutuality, unmotivated by social exchange, and unmoved by the feelings and desires of others, except as these interfere with their own needs and wants. Hobson (2005) puts it this way: Children with autism “do not seem to share the world with other people, and they do not relate to the world-according-to-the-other” (p. 197). While, as connoted in the notion of an autistic spectrum, the degree of impairment in mentalization varies from individual to individual, disruptions in the capacity to hold the other (and the self) in mind are common to many, if not all, children on the spectrum.

Thus, while typically developing infants are drawn to form relationships from the earliest days of life, and are enlivened, stimulated, and immensely rewarded by social exchange, children on the spectrum generally fail from very early on to orient to social stimuli, namely, faces, smiles, affect cues, and the like, and instead prefer inanimate (Volkmar et al., 2004) or perfectly contingent (Gergely, 2001) stimuli. Thus, rather than offering dynamic opportunities for self-discovery and regulation, emotional or relational experiences are often highly disorganizing and dysregulating and are thus avoided. Not only does this profoundly isolate the child, but it also deprives him of the many forms of self and relational knowing that evolve out of primary relationships.

This is not to say, of course, that children on the spectrum do not have an inner life. They do. What they struggle with is the ability to use the mind of the other to help them make sense of internal experience; in addition, they lack the tools to communicate the thoughts and feelings they do have to the other, who is—in many respects—far too stimulating and confusing.

In the sections that follow, I am going to describe some of the ways that the spectrum child’s unique difficulties processing social stimuli and hence making sense of the minds of others pose complex and ongoing challenges for their parents. In particular, I will highlight three crucial ways in which the parent of a spectrum child must mentalize the unmentalizable.

Finding Oneself in the Mind of the Other

Winnicott (1965), Stern (1985), and later Fonagy (Fonagy et al., 1995) developed the notion that the child first finds himself in the mind of his mother (or father). That is, the mother’s capacity to hold in her own mind a representation of the child as having feelings, desires, and intentions allows the child to discover his own internal experience via her representation of it (Fonagy et al., 1995). Her observations of the moment to moment changes in the child’s mental state, and her representation of these first in action and later in words and play are at the heart of sensitive caregiving and are crucial to the child’s ultimately developing mentalizing capacities of his own. Gergely and Watson (1996) have

drawn particular attention to the ways in which the baby learns about his own self-states by seeing them mirrored in his caregiver. They suggest that the child is not born with the capacity to recognize primary, constitutionally generated, affect states as meaningful self states. Rather, sensitization to and eventual understanding of self-states is first brought about by parental affect mirroring. Thus, it is through mothers' "marking" of their very young infants' affect displays, producing an exaggerated version of realistic emotion expressions such that the infant's state is reflected back to him as a "re-presentation," that the child first begins to organize his self experience. The infant first learns about mental states as he observes them in his caregiver as representations of his self-state; only then can he begin to recognize them in himself. In Winnicott's (1965) terms, the parent "meets" the infant's spontaneous gesture, giving it life and meaning.

But what if the parent's natural and evolutionarily selected inclination to locate the infant's self states and mirror them is disrupted by the fact that cues to his internal experience are counter-intuitive, overwhelming, frightening, odd, subtle, or nearly imperceptible? *What if she herself cannot find the child, let alone reflect this discovery back to him?* What if the child's spontaneous gesture makes no sense to the parent *and* hurts her feelings? With children on the spectrum, the signposts that ordinarily help parents make sense of their child's internal experience, such as eye contact, typical indicators of pleasure, pain, fear, and sadness, directed communication, and the like are missing or disrupted. Thus, the re-presentation and affect mirroring that allow the child to discover his own internal experience cannot take place, or takes place in a distorted way, largely because the normal and quintessentially human process of figuring out what is in another's mind becomes terrifically and frighteningly complex. The parent is left with the task of locating the child's mental states in the sea of confusing and chaotic communications, communications that seem, at least in the beginning, so utterly *not* communicative. She must mentalize what seems at first, second, and even tenth glance unmentalizable.

Meeting the Mind of the Other

Adding to the complexity of the situation is the fact that the parent must make sense of her child's mind without the rewards of reciprocity and mutuality, or what Kalmanson (this issue) describes as the "typical developmental experience of cascading pleasure taken in shared looking, vocalizing, and movement" (p. 45). "Getting it right" in the early relationship is hugely pleasurable and motivating because the child thrives. As Benedek (1959) described long ago, these moments are essential to the parent's feeling like a "good" parent and thus a "good" self, and provide crucial opportunities for creativity, repair, and profound gratification. In addition to thriving, the child *reciprocates*. That is, the mother's ability and indeed great eagerness to sort out what the child is first feeling and later thinking, coupled with the child's biological readiness to engage and be understood, together set the stage for what Stern (1977) so beautifully described over 30 years ago as the "dance" of human interaction, the mutual and mutually rewarding exchange that is at the heart of satisfying intimate relationships. Think, for example, of the moment the child stands for the first time. As he stabilizes his precarious balance, managing to finally distribute his weight forward on the balls of his feet, he looks expectantly to his mother for her response. She, of course, has been anticipating this moment for months and literally explodes with delight. Her enormous pleasure is like fuel for his engine. He grins back at her and steadies himself even more, standing straighter and straighter in the sunshine of her affirming gaze. Their shared pleasure is like a string pulling him upward, and eventually, forward.

In this reciprocal dance, not only does the mother come to know the child's mind, but he also knows hers. Just as she engages with his mind, he engages with hers. Thus, the mother's motivation derives not only from the child's pleasure but also from her own pleasure at the child's openness to and interest in her mind. Part of his pleasure is that his mother is so happy. And part of his motivation is to make her even happier. His implicit recognition of her mind, and indeed the *mutual recognition* of each other's minds, is a crucial piece of her feeling sustained and rewarded by their relationship. In this way, mentalization is not simply unidirectional but also rather an inherently reciprocal, dynamic, and mutually rewarding process.

Because of their grave difficulties making sense of and deriving pleasure from the other, repair, reciprocity and particularly reciprocal mentalizing are very hard won for children on the spectrum. Even the most sensitive parents can be thrown by the ways in which their children can seem so unaffected by those around them, and so bound up in their own realities. Indeed, parents are often left feeling that they have no self left at all in the face of their children's obscure and relentless priorities and rigidities. Because these rigidities emerge as a function of their children's efforts to create sameness and predictability, and to avoid the complexities and confusion that are inherent in social dialogue, children on the spectrum rarely, at least before treatment, "give back" in the ways that are essential to a parent's continuing to feel gratified and fulfilled by the complex tasks of parenthood. Think, for instance, of how the enormous challenges of an infant's first six weeks, when he seems largely disinterested in human or social engagement, other than to satisfy his needs (hence, Mahler et al.'s (1975) use of the term "autistic" to describe this period), are almost instantly resolved by the first social smile. Suddenly, the child is a person (not simply, as one father put it "one long alimentary canal"), gratified by relating to other people. For the parent of the child on the spectrum, this experience may be years in coming. One parent I worked with, whose 10-year-old daughter had Asperger's Syndrome, came in and told me, with great feeling, that after many years of treatment she had finally and for the first time told him she loved him. This had been accompanied by another first, a *real* hug.

Mentalizing the Unbearable

This sort of simple and human reciprocity goes a long way toward helping manage and regulate the negative feelings that are as normal a part of parenthood as the pleasurable ones. Indeed, negative affect is a fact of life in all human relationships, and certainly in the parent-child relationship. However, as pointed out by Fonagy and his colleagues (Bateman and Fonagy, 2004), intense negative affects make it especially difficult to attend to or even be curious about what is in another's or one's own mind. That is, negative affects such as fear, sadness, and particularly anger are more difficult to mentalize and thus regulate than positive affects. Yet, moments of intense affective arousal and dysregulation are those that most require mentalization.

This poses a particularly difficult dilemma for parents of children on the spectrum, who must cope with more and more prolonged and intense anger, sadness, grief, shame, fear, and dread than the parents of typically developing children. These feelings are provoked by so many aspects of their daily lives, by the external realities of finding and maintaining a complex array of services, but more centrally by the very difficulties that are at the heart of their child's condition, namely his social avoidance and inability to reciprocate. Their child is not easily soothed, comforted, or understood; he can be enormously rejecting and obtuse; and he can be very demanding. His developmental course is unknown and likely bleak. And, although anger, disappointment, sadness, and

anxiety will ebb and flow in intensity, they don't ever go away; they just get managed (Crown, this issue). What this means is that the parent's own mentalizing abilities, however robust, are relentlessly challenged by intense negative effects.

Add to this conundrum the fact that many of the feelings they feel are *not feelings any parent is comfortable feeling toward her child*. In this way, they are often simply unbearable and unmentalizable. Hate, in particular, is unspeakable, even unthinkable. It is the rare parent of a child on the spectrum who can hold and feel such feelings without terror. Implicit in a mentalizing stance is the awareness that a feeling is just a feeling, just a state of mind. Indeed, mentalization is possible only when a feeling is regulated to the degree that it can be contemplated and symbolized. This is why humor and playfulness are so often indicative of mentalization; an experience must first be symbolized before it can be played with. For the parents of atypical children, however, the distance that is intrinsic to mentalization can be ephemeral. Feelings of this depth and intensity are too live, too dangerous, and potentially destructive to be reflected upon. For example, few if any parents of an atypical child would ever say something like the following to their child: "You know, if you do that again I'm just gonna' have to kill you!" Yet, mothers of typically developing children say things like this all the time. They can express such bare aggression because, as exasperated as they may be at the moment, there is likely little danger in this fantasy. It captures a fleeting impulse, not an unacknowledged and shameful longing. For the parent of a child on the spectrum, however, the impulse might just be too close to a deep wish, a wish that she hides even from herself. Even joking about such a terrible possibility threatens connections that feel vulnerable enough already. Thus, these private darkneses remain unintegrated and unmentalizable.

One consequence of this conundrum is that what is so often presented to the child (rather than re-presented) are the parent's own—often unmetabolized or unmodulated—feelings. That is, many children on the spectrum, particularly in the period before diagnosis, are confronted on a regular basis with parental affects that would even under normal circumstances be quite difficult to tolerate and integrate. That is, the exchange with the parent is often tainted, from the very beginning, with largely unmodulated parental anxiety and anger. This anguish must play a role in the interaction very early on, long before the parent is conscious of her concern. A typically developing child faced with intense parental affect would likely avoid the mind of the other because of its inherent threat to the coherence and integrity of the self (Fonagy et al., 2002). In the case of a child on the spectrum, however, the mind of the other is already frightening and disorienting. The additional complexity of the parent's negative affects would make it even more so, and thus even more likely to be avoided.

In addition, parental projection, a normal feature of all relationships, can take a particularly pernicious turn in the parents of children on the spectrum, in part because negative affects can be so readily triggered. I recently heard about a young mother whose concern for her infant son was piqued when her own mother remarked, "He *hates* me!" after spending an afternoon with her grandson. When asked why, the grandmother noted that he always turned away when she held him. The mother then asked her husband's mother what her experience with her grandson had been; sadly, she received the same response, "Oh, he *hates* me." She cited the same reason, namely, his avoidance of close contact. These two observations were the first step in discovering that the child had autism. What is especially poignant in this example is that both grandmothers interpreted the infant's social avoidance as evidence of hate. Under different circumstances, such projections would have colored these developing relationships forever.

Despite such complex challenges, the requirement that they remain organized and regulated, that is, that they continue to mentalize, is rarely, if ever, relaxed for parents of children on the spectrum. For one thing, as described by Crown (this issue), the child cannot tolerate it. Even the most normal frustration and distraction can be utterly overwhelming and disorganizing to the child. In fact, sensitive parenting, in its many aspects, is *as if not more* crucial for the child on the spectrum, whose fragile capacities require a very special kind of scaffolding and parental presence. These children form powerful attachments to their parents (Buitelaar, 1995; Dissanayake and Crossley, 1996; Naber et al., 2008) and are enormously helped and sustained by their primary relationships. Indeed, as Crown (this issue) makes clear, they need their parents more and for longer than other, more typically developing children. Add to this the fact that, because their capacities for relatedness are so challenged, children on the spectrum likely have fewer other relationships to which they can turn for nurture and comfort. Thus, the parents are often, in terms of the child's reality, especially central and important to their psychological and physical survival and will be so for most of their lives. While these challenges can bring what Crown (this issue) refers to as "unexpected gifts" and a deep sense of fulfillment, such enormous rewards are not without profound complexity.

CLINICAL IMPLICATIONS OF THE MENTALIZING PARADOX

From the standpoint of contemporary psychodynamic theory, it seems obvious that the mentalizing paradox is at the heart of the well-documented chronic and pervasive stress that is part and parcel of parenting a child on the spectrum, stress that is heightened when the child's disorder is particularly severe or manifests in behavioral acting out or when the parents themselves are vulnerable psychiatrically, which, for genetic reasons, includes many parents of children on the spectrum (Hastings, 2008). These ubiquitous stresses are compounded by the fact that parents must both coordinate a wide array of services for the child (often in the face of inadequate information and little education about the options), as well as serve as *in vivo* therapists throughout most of his (and their own) waking day. This is true whether the treatment is dynamically oriented (as in Greenspan's DIR/Floortime model; see Greenspan & Wieder, 2006) or behaviorally focused (as in Applied Behavioral Analysis; Cooper, Heron, and Heward, 1987): parents are an *intrinsic and essential* part of the child's treatment for years.

Nevertheless, despite the fact that the parent's capacity to negotiate this paradox and its sequelae will vastly improve her ability to deeply and meaningfully engage with her child and thus the child's attaining crucial social, emotional, cognitive, and sensory milestones (Greenspan and Wieder, 2006), models for treating spectrum disorders focus almost exclusively on the needs of the child. This is not hard to understand, in one sense. From the moment of diagnosis, children on the spectrum require an array of intensive "wraparound" services to ensure even modest developmental gains. Indeed, their needs are profound. To extend the wraparound metaphor, parents are often left out in the cold. Typically, services for parents are add-ons that are organized and implemented by the parents themselves, usually outside the child's treatment program. Often, these are implemented when the parents' pain and suffering become extreme and threaten to derail the child's progress. However, within the framework of the treatment models themselves, the implicit or explicit message to parents is a version of the following: "I know this is hard, but if you soldier

on, your child will get better, albeit slowly.” Take, for example, the following excerpt from an article posted by psychologist Laurie Pelloquin on the Floor Time website (www.floortime.com):

Casey, age three and one-half, sits on the floor, pushing a truck back and forth, with no signs of enjoyment in what he is doing. His mom pushes a small car next to his but instead of looking up at her, he moves his truck a foot away and starts again. His mom pushes her car into his truck so they make a crashing noise. Casey picks up his truck and this time, moves across the room, turning his back on her. His mom finds a train and sets it down next to him. As he picks up the train, she takes the truck, until Casey reaches for it, and then she gives it right back, making a trade: first the train, then the truck, around in a circle, back and forth, back and forth.

Success! Casey is beginning to accept his mom as part of his play. However, this has taken months of work. Casey’s mom has gently, patiently, and persistently searched for a way to make interaction fun, looking for a change in his expression, the gleam in his eye that tells her a connection has been made. This is the process of Floor Time and wooing the child into interaction. Finding a way to make being with others pleasurable and interesting; following the child’s lead; keeping the interaction going - this is the heart of the DIR approach.

The words that stand out to me in reading this passage are the following: “months of work... gently, patiently, and persistently searched... looking for a change in his expression... gleam in his eye... wooing the child into the interaction.” Anyone who has worked with an autistic child knows just how hard this is, even for a trained clinician. For the parent, however, struggling to manage so many powerful feelings, struggling to hope and to feel attached to a child who is so forcefully rejecting her, it can be excruciating.

While the message of persistence and patience is, on the face of it, fairly accurate and may be necessary to motivate parents, it cannot help but ring hollow to many over time. It is not possible to soften denial by unwittingly colluding with it. We soften denial by hearing its aim: the defense against great and nearly intolerable pain. Interestingly, a recent report suggests that many parents of children on the spectrum are dissatisfied with their treatment options (Bitterman et al., 2008). While there are many reasons for this, one may well be that their own pain and difficulty often goes unacknowledged and unaddressed, except when it becomes so pressing as to threaten the child’s progress. Yet the language of this dynamically oriented Web site, typical of the language of so many of the materials available to parents, is relentlessly optimistic and upbeat. It is easy to imagine how these exhortations would make a despairing parent feel.

It is also easy to understand why many parents and families would at least initially resist a more complex view of their experience as parents, and why service providers would as well. Meaningful parental support is extremely costly, time intensive, and sometimes even disruptive to both parents and staff. Focusing almost exclusively on the child, on concrete educational and behavioral strategies, and on guidance and advocacy is far easier than entering into the messy world of emotions, especially when they are so complex and powerful. In this sense, the relative neglect of the parent’s psychological life suggests a fear within care delivery systems that grappling with such complexity would derail the work; indeed, most care providers (unless they are trained therapists themselves) are unprepared to address and manage it, and most parents do not know how to even begin to untangle the myriad of feelings that often engulf their daily lives. Thus, there is often a kind of shared collusion and a shallow optimism that relies upon bland denial of the depth of the parents’ emotional experience.

Of course, as so vividly exemplified in Kalmanson’s paper (this issue), some parents are fortunate enough to find an experienced and gifted therapist able to hold their pain at individual,

dyadic, and triadic levels, while at the same time address the child's (or in this case, children's!) developmental needs. Kalmanson describes her particular approach in this instance as "wedding infant-parent psychotherapy with a DIR developmental approach" (p. 44). In instances such as this, the child and his parents are all beneficiaries of the therapist's flexibility, sensitivity, creativity, courage, and extraordinary resilience. Indeed, the contemporary literature on autism contains numerous clinical examples of thoughtful, nuanced, and healing work with parents in dyadic, individual, or couples' work (Drucker, this issue; Greenspan and Wieder, 2006; Wieder, Greenspan, and Kalmanson, 2008). Many of these treatments do indeed address the fundamental challenges of mentalizing the unmentalizable. Even within strict behavioral protocols, many practitioners (whether or not they are trained mental health clinicians) are regularly called upon to address parental struggles and conflicts (Hillman, 2006). Indeed it is hard to imagine that, given that parents *are* such an intrinsic part of treating child autistic spectrum disorders, treatment could ever really succeed if parents did not feel supported and if the depth and breadth of their trauma were not understood and "held" in some way, whether within or outside of the child's treatment. But—and this the crucial point—these issues are rarely specifically addressed in the development of treatment models.

I came to appreciate the importance of incorporating parents into the treatment of spectrum disorders when I worked with a child with Asperger's Syndrome and his family some years ago. David, age four, was brought to me by his guardians. Selectively mute and extremely avoidant, David had been adopted at one and a half by his maternal uncle and his wife after his mother's mental illness rendered it impossible for her to care for him. Because of his mother's illness, his uncle and aunt (who were in their fifties) had been very close to him since early infancy and often stepped in to care for him well before he and his wife formally took him in. While the uncle had noted the child's oddness very early on and had in fact initiated an evaluation at a local children's hospital when David was three, he nevertheless enrolled him in a private preschool, which, unable to manage him, eventually referred the family to me. It was not until he was six, after over a year in a very responsive public school, that his diagnosis of Asperger's Syndrome became clear.

Leo and Marlene were childless, and Leo had always desperately wanted children. He had lost his own mother in childbirth and had been raised in abject rural poverty by a maiden aunt. As an adult, he was outgoing and gregarious, a "people pleaser." Marlene, who had been very ambivalent about having children, was herself quite constricted and limited by her rituals and need for order. More important, there was severe mental illness on both sides of the family, with Leo and Marlene the most functional of their siblings and cousins. Prior to David's arrival, they had struggled for control in a myriad of ways but had nevertheless maintained a distant but functional marriage.

Over the course of our work together, I saw each of them with David, I saw them each individually, and I saw them as a couple. What was striking was that while Leo and Marlene were overtly compliant and eager for any kind of support I could provide them, their capacities for mentalization were quite limited. Leo was profoundly identified with David as the abandoned child, and as a result had a great need to both gratify and rescue him. Thus, although he was surely David's psychological lifeline, "seeing" the child in any kind of complex, nuanced way was very difficult for him. As a result, he could set few limits on the child's disruptive and disorganized behavior and had little appreciation of the depth of his nephew's disability or the urgency of his developmental needs. As a result, the household was at the mercy of the child's demands and idiosyncracies.

By contrast, Marlene found the child almost unbearable. The insertion of this young and very difficult boy threw everything into chaos for her, and she was enraged. Here she was, saddled with

her husband's sister's son, who she saw as only manipulative and "bad." While Leo appreciated that the child could not be forced or directly challenged, Marlene insisted upon limits and punishment. She simply could not imagine what it was like for the boy and was constantly disappointed and infuriated by him. She coped by withdrawing from them both, as well as from David's mother (who finally came to live with them), leaving uncle, mother, and child to stew in their own (often extreme) dysfunction. The discrepancy in Leo and Marlene's equally inaccurate views of David was highlighted with a psychologist testing David asked each of his caregivers and his teachers to rate his behavior. Leo defined few problems, Marlene saw everything as problematic, and the teacher fell in the middle, closer to Marlene. Where was David in all this? Who was David?

In this situation, David's entry into the family revealed pathology that both Leo and Marlene had successfully managed prior to his arrival. Splits and rifts that had remained underground, manifested only in the dance of Leo and Marlene's interactions and struggles for control, were unleashed in all their destructive power. When they were, David and his needs were lost, and for his guardians, projection replaced any potential mentalization. Leo was lost in his efforts to gratify the child he wished he had, and Marlene was lost in her fury. Most certainly, Marlene and Leo were lost to each other.

As my work with this family progressed, I began to see that Leo and Marlene needed as much—and finally more—attention than David. After a two-year course of play therapy with David, during which time I saw his caregivers and particularly Leo regularly, I came to feel that the child's needs were best addressed within a school setting. At this point, I began to see Leo weekly; slowly and fitfully, he began to separate his own anguish (over his own early losses, his childlessness, and his limited marriage) from David's developmental and emotional needs and realities. As he progressed, David became more manageable. Marlene was, however, far more reluctant to come to sessions and tended to use these to offload her rage at both Leo and David. Her negative effects were so unrelenting that she could rarely take a mentalizing stance. Needless to say, this standoff limited whatever progress the family and particularly David were capable of.

While unique in its particular details, this kind of situation is not rare. Yet to reiterate this crucial point, the depth and breadth of parents' needs in such circumstances have never received the kind of attention they require at the programmatic, conceptual level, within either dynamic or behavioral paradigms. While they are often addressed at an individual level, the fact that parental needs are not incorporated in a meaningful way into the treatments themselves implies that such struggles are not ubiquitous and indeed normal under such circumstances, but pathological. Pathology will make them worse, certainly, but they are not in and of themselves pathological. Indeed, they reflect a normal response to the fact that their natural and human desire to develop a relationship with their child has been profoundly derailed.

Shifting the emphasis in prevailing treatment models will surely be challenging, and there is clearly no simple solution. I would offer several suggestions. The first, obviously, is that services and supports for parents be integrated in a meaningful way into all treatment programs. In my opinion, the gold standard for such work is the blend of individual child, dyadic, and individual adult work described by Kalmanson (this issue) in which the interaction and the parent's own emotional anguish are the focus of treatment. But few communities have the deep and wide resources to provide this level of care for parents. Group treatments are another option. Within the field of infant mental health, the infant-parent psychotherapy models developed by Fraiberg (1980) and her colleagues (Lieberman, Silverman, and Pawl, 1999) have recently been extended into group settings, sometimes with a specific focus on the development of mentalization (Cooper

et al., 2005; Grienenberger et al., 2004; Puckering et al., 1994; Reynolds, 2003; Slade, 2006). These group models bring together psychoeducation, observation/videofeedback, and the principles of dynamic psychotherapy. For parents of children on the spectrum, both psychoeducation and observation seem crucial, the former because introducing parents to the mentalizing paradox gives them a framework for understanding their distress and the latter because mentalization is facilitated when the interaction can be closely observed and experienced within the safety of a therapeutic situation (Schechter et al., 2006). A group approach also has many practical benefits, not the least of which is time and cost efficiency, as well as the lessening of parental isolation and treatment fatigue.

It is also worth noting that while many adult psychotherapists end up treating the parents of children on the spectrum, they may or may not have any understanding of these syndromes. In my view becoming educated about the spectrum disorders and their multiple exigencies is essential to the therapist's ability to hold all the complexity of the mentalizing paradox for her individual patient.

The Mentalizing Paradox and the Child's Care Providers

It is not only parents who must navigate the paradox of mentalizing the unmentalizable. So must the child's care providers, including therapists, teachers, and so forth. For some, this is a manageable task. For others, it is an enormous challenge, one that may lead to abandoning basic efforts at mentalization. This is particularly the case when the training does not in any way prepare these providers to manage the mentalization paradox, although even the most skilled and talented dynamic therapists burn out after years of working with children on the spectrum. Countertransference provides a useful frame for understanding many of the intense reactions practitioners have to these children; like the parent, practitioners wish to help and even rescue the child who is enormously difficult to read and reach. The strength of these desires coupled with child's imperviousness creates enormous opportunity for projection and other countertransference reactions. These responses can make it difficult to see the child for who he is and to appreciate his needs for what they are. Under other circumstances, they may be catalysts for change.

I took a job working at a psychodynamically oriented day treatment center for autistic children after graduating from college. The center emphasized intensive individual work with each child, with the aim of restoring disrupted capacities for relatedness through the therapeutic relationship (Mahler and Furer, 1968; Franknoi and Rutenberg, 1971). Interestingly, although we no longer think of the autistic child as having *ever* had intact capacities for relatedness, and thus would not use the term "restore" in this context, the notion that the disorder reflects a disruption in the earliest efforts to establish human, social contact is very much in keeping with current thinking about the biology and neurobiology of autism. In any event, I was assigned to only two children for an entire year. I worked with one boy all morning and another all afternoon, every day. Gordon, age nine, was my "afternoon" child. My experiences working with him, and in particular my attempts to make sense of and manage his imperviousness and rigidity alongside my own anger and frustration at these very attributes, were my first encounter with the mentalizing paradox of working with children on the spectrum.

Gordon gave new meaning to the expression "creature of habit." Every afternoon, immediately upon arriving at the clinic, he would fold one piece of pink construction paper and another piece of blue construction paper together into a sort of booklet. Then, clutching this freshly made talisman

in his hand, he would make his way to the pantry, where he would help himself to two Nabisco Raisin Bars and pour himself a cup of coffee, loaded with milk and four spoonfuls of sugar. He never took three Raisin Bars or three spoonfuls of sugar. And he *never* ate any other kind of cookie. He would then make his way to the playroom, gesticulating wildly and talking to himself the whole way. Finally, he would sit down and have his coffee. If any small thing went awry, he would grab at his genitals and screech, his eyes casting about, or erupt in floods and floods of desperate tears. This was only one of his many, many rituals, rituals that were essential to his functioning.

Day after day, this routine began to grate and tear at my patience. It made little sense to me, and the more frustrated I got, the less sense the routine made. In retrospect, his behavior actually makes a lot of sense to me: he had just had a long morning at school, a tedious bus ride, and he was ready to take a break. But then, as a young therapist with little experience, I was eager to help him, eager for change, eager to *have an impact*. I resented the monotony, I resented how little I seemed to be accomplishing. Did we always have to do things the very same way? What if there was a special activity scheduled at arrival time...couldn't he just wait? Much more deeply, I must have felt angry and hurt that our relationship had failed to penetrate his rigid boundaries.

Slowly I did jiggle his routines a little. Over the course of our year of working together, I helped him learn that going left when he always went right wasn't so bad after all. There were no catastrophes, and sometimes it was even fun. Sometimes I could be playful when I was feeling shut out; interestingly, these were often the moments when he would become the most engaged with me. I first broke through to him when, after watching him spend hours during recess "riding" a tricycle around and around the play yard, smashing it at regular intervals into the wall, I insinuated myself into the game by pretending to chase him. Suddenly, he wasn't just running and smashing, he was running *away* (in itself a relational stance) and laughing. On another occasion, when we were walking on the hospital grounds adjoining the center, I reacted to feeling shut out by his muttering and gesticulating by playfully heaving an armful of autumn leaves at him. This quickly became a game, with us both heaving large piles of leaves at each other, burying each other, hiding from passersby, convulsed in laughter.

On another occasion, after he had been muttering the same television commercial under his breath from the moment of his arrival, I asked him to stop. He kept right on muttering, impervious to me. We happened to be in the bathroom, where I was filling up a big bucket of water. It was a hot summer afternoon and all the children and staff were washing the staff's cars. Gordon was prancing around beside me, singing his heart out about cat food. In a flash of what I now like to think was inspiration (and not total frustration), I turned and gently, playfully, heaved the entire bucket of water at him. For a second, when he realized what had happened and looked down at his completely drenched clothes, I thought I might have made a big mistake. There was true panic in his eyes. But within seconds Gordon quickly realized I was *playing*, and that this was, in fact, both fun and very funny. Soon he was bent over with real laughter. For weeks he tried to get me to douse him again, just as he had tried to get me to chase him and to heave more leaves at him.

At other times, however, my complete frustration and sense of futility wiped out my ability to play, or to keep him in mind, even a little. Another of his habits was to take out two Doctor Doolittle books whenever we visited the library, which we did frequently. It didn't matter which ones (after all, he had read them all, many times over), he just had to take two, not three. One day I decided that now would be a good time for Gordon to let go of this routine. Within minutes I found myself embroiled in a tug-of-war over a Doctor Doolittle book *on the stairs of*

the local public library. Suddenly, I came to my senses. *What was I thinking?* Needless to say, he left the library with his Doctor Doolittle books, and I left feeling both insensitive and silly.

Gordon left an indelible mark on me. What I am struck by now is how many of the things that “worked” grew out of my efforts to manage and transform my frustration at his isolation and inability to let me in. Fortunately, my aggression was sufficiently modulated to be helpful to him, largely because most of it was expressed in a playful way. Only, as in the last example, when I could not be playful and became so frustrated that I failed to mentalize was my work counterproductive.

These struggles are an essential aspect of any practitioner’s work with a child on the spectrum. I had the good fortune to be in dynamically oriented supervision throughout that year. I now realize what a luxury that was, both for me as well as for Gordon. This kind of close attention to process, to one’s own experience as a care provider, which is so rare today, is invaluable. Practitioners are as vulnerable as parents to the mentalizing paradox and to the feelings it engenders. While it will hopefully never have the depth and intensity that it does for parents, it can nevertheless play a crucial role in service delivery across a range of disciplines.

CLOSING COMMENTS

My primary purpose has been to use contemporary mentalization theory as a framework for understanding the particular dilemma faced by parents of children on the spectrum, namely, that they must parent their child in the relative absence of reciprocity and mutuality, and in the presence of their own strong and disabling emotions. Contemporary psychoanalytic developmental theories offer a way of understanding the depth and breadth of this conundrum, and dynamically oriented parent work or dynamic psychotherapy offer a means to adaptation and comfort. For the vast majority of parents with children on the spectrum, although their great vulnerability and need have been well documented, little attention has been paid to their internal experiences or their struggles feeling and remaining attached to their children. While many persevere and flourish despite the absence of a coherent approach to addressing their needs, it is essential that clinicians develop approaches that can be more widely implemented and accepted and that help parents negotiate and come to terms with the challenge of mentalizing the unmentalizable.

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