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SITTING WITH INVISIBLE DIFFERENCE: PSYCHOANALYTICS AND AUTISM

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Psychoanalytic psychotherapy and autism have had a complicated relationship. Much of the complication has arisen from patients with autism being misunderstood by those who have used a psychoanalytic lens. These misunderstandings arose not for a lack of trying—but rather from a disavowal of how neurological difference shapes what it means to become a person, and how these differences affect treatment needs. It has been autistic patients who have had to bear the consequences of these misunderstandings in much the same way as they do in their daily lives outside of therapy. It is not the psychoanalytic lens that has failed these patients, but rather its use without reference to the ever-growing body of neurobiological knowledge. In this paper, we make the argument that many of the key psychoanalytic concepts—countertransference, the frame, narcissism, intellectualization and obsessions—need to be reviewed and altered when working with autistic patients.

KEYWORDS: AUTISM, DIFFERENCE, DISABILITY, NEURODIVERSITY, NEUROLOGICAL, PSYCHOANALYSIS, PSYCHOANALYTIC PSYCHOTHERAPY

INTRODUCTION

Being a psychoanalytic psychotherapist today means practicing in a time where there are incredible advancements in finding neurobiological correlates for psychoanalytic concepts. There is hope that a more nuanced understanding of the brain can provide objective explanations for phenomena that psychoanalytic therapists regularly encounter. There are specific psychological phenomena that appear to enjoy focus when it comes to studies that explore the neurodevelopmental components of experience and behaviour. Autism is one such phenomenon—while acknowledging that other neurodevelopmental disabilities are equally in need of focus. 'Neurodiversity' refers to the way that human brains are diverse and, as such, we are all neurodiverse. 'Neurodivergent' refers to people with neurocognitive differences that mean they are outside the neuronormative/average developmental norms for

neurodevelopment (Murphy, 2023). In the case of autism, this means social and communication differences, sensory differences, areas of specific and intense interest, a preference for predictability in cognitions, thoughts and events, different ways of regulating one's nervous system and needing structure or novelty (Day et al., 2024).

Critical autism studies (interdisciplinary research field led by autistic people) challenge us to unlearn some of what we have been taught around how to care for, alleviate distress and formulate according to deficit-based descriptions (Kinderman et al., 2013). We are asked to develop new practices that move beyond epistemic injustice surrounding the autistic experience and to step into epistemic humility, embracing new ways of supporting autistic people. A neurodevelopmental perspective that accounts for how these differences in brain structure and function may culminate in experiences holds the promise of a deeper level of understanding of the patient. However, one wonders what the fantasies may be about how psychoanalysis could be better positioned to help patients with autism when drawing on scientific evidence of neurological differences. What would the neurological evidence be a substitute for? The patient's supposed inability to account for their own experience? The psychotherapist's inability to look beyond conventional understandings and expectations of how someone should *be* in the world? Are we saying, in the absence of neurodevelopment knowledge, the psychoanalytic psychotherapist is at a disadvantage when equipped only with their sense of the patient, their capacity to listen, their ability to weave together a historical narrative and their willingness to interrogate and use their own countertransference? If the answer is yes, we need to consider why this might be.

According to Krass (2020), autism presents psychoanalysis with a challenge to how specific frameworks of the mind were constructed—autism asks what our psychoanalytic theories of human development and behaviour would look like when considering a brain that is different. Most attempts to provide a psychoanalytic account of autism focus on how it develops. It is debatable how useful these attempts have been as far as the extension to clinical practice. In 'Autism: A Battle Lost by Psychoanalysis', Benvenuto (2019) argues that the focus on how autism develops, rather than a thorough understanding of what autism is, has hindered otherwise nuanced attempts at theorising from capturing the essence of the phenomenon. Included in these attempts is Bettelheim's (1967) and Tustin's (1969, 1980, 1981, 1990). Importantly, Tustin was pro psychotherapy when it comes to autism. Perhaps, consciously or unconsciously, Tustin and Bettelheim were attempting to establish a developmental foothold that would legitimise psychological interventions for autism (Tustin, 1967). Gombosi (1998) appears to have captured something of this:

> At times, a patient will need us to hold a meaning that he cannot yet represent, and this may be especially true of someone recently traumatized, but it does not speak to the quality of disquietude, of dislocation, we experience in the circumstance…The analyst must confront his own feelings of being faced with

> something that is irresolvable by analysis just because it is tragic. (I believe that the failure to do so is at the root of the error made by those who insist on the psychogenetic nature of autism.) (p. 261)

The purpose of this paper is not to review the psychoanalytic developmental theories on autism. We do not refer to these theorists and clinicians to side with Benvenuto in the view that psychoanalysis has lost the battle with autism. Rather they are included because they have attempted to represent autism from a psychoanalytic perspective—something this paper sets out to grapple with. A developmental understanding of autism is important; however, we need to be clear on what we as clinicians imagine a developmental understanding of autism will enable those who work with autistic patients to do. What are we working our way back from, what are the misunderstandings and impasses between patients with autism and psychotherapists that would be addressed via a developmental account?

What many of these accounts appear to have in common is that they are descriptive with seemingly forced theoretical underpinnings that fail to capture the essence of an individual that is structured via difference—what does sitting with an autistic person in the psychotherapist's room look and feel like? As much as Benvenuto (2019) attempts to highlight the ways in which psychoanalysis has failed autism, he also adds to and relies on the notion that what the autistic patient struggles with is some form of lack. With many of these texts the aim seems to be to satisfy the theorist's/clinician's need to account for a particular phenomenon. What is required is a theoretically informed approach aimed at capturing the individual's unique/different experience of their world. We cannot get around the fact that psychoanalytic theory has been normed on the notion of neurotypical brains—we are not saying that it is not valid, but we need to use these theories with care, continuously learning from the patient how they are structured—in relation to psychoanalytic theory from the position of being autistic. If psychoanalysis has failed autism, and perhaps it has, it is because it does not entirely account for autism.

Is this why much of the thinking around autism has been in spaces that focus on behavioural modification, positioning autism as a purely cognitive behavioural difficulty—essentially implying that the disconnect between knowledge and demonstrated ability captures the heart of the issue? To view autism as a form of lack is to position it as a one-dimensional difficulty; it does not address the performative nature of language and the way in which the individual's sense of self has been structured by their difference. This thinking appears to be endemic in much of the psychoanalytic writing on autism. Benvenuto (2019) critiques historical psychoanalytic conceptualisations of autism, providing examples of professionally held views on autism that include the notions that individuals with autism typically do not possess a sense of humour, they lack erotic desire, and they are incapable of perceiving the subjectivity of others. Ironically and tragically, these types of statements have the appearance of the very concrete thinking that autistic people were supposed to exhibit. Is what we are seeing a kind of 'autistic' countertransference where theorists stand on the outside of a phenomenon that they are not attempting to conceptualise

experientially, relying only on predetermined notions of behaviour that are used to assume how an individual who is different goes about being a person?

Considering the complex interplay between neurodevelopment and psychology there is a profound amount of variance in how autism is expressed and experienced, hence the popular phrase, 'if you have met one person with autism, you have met one person with autism'. There is a need to develop psychoanalytic understandings of the identified aspects of autism—something this paper aims to do—to provide examples of how psychoanalytic thinking can be used to make sense of difference with a specific focus on the individual's experience, and how their experience impacts on the therapeutic encounter.

WHAT IS AUTISM?

To explore autism meaningfully, a definition is required. The notion that autism manifests on a spectrum, and that the way it is experienced and expressed is deeply interwoven with personality and personal experiences can drive a theoretical exploration to the extremes of relativity. Ultimately, this is of little use other than countering rigid and oversimplifying definitions of autism. However, we need to begin somewhere; we will use the American Psychiatric Association's (APA) definition of autism, since that is what we have, to illustrate how the nuances in subjective experiences of the individuals described by this definition fall by the wayside:

> Autism spectrum disorder (ASD): any one of a group of disorders with an onset typically occurring during the preschool years and characterized by varying but often marked and persistent deficits in social communication and social interaction, including difficulties with social-emotional reciprocity, nonverbal communication behaviours, and social relationships, along with restricted and repetitive patterns of interests, behaviours, and/or activities. (APA, 2023)

This definition, when viewed through a psychoanalytic lens, holds the potential to provide many different understandings of what autism is. Is the notion of 'deficit' to be taken up as a non-specific absence of demonstrated desire to be in relation to others? Where do we locate the 'deficit'—in desire or in the ability to demonstrate, communicate and negotiate desire? A psychoanalytic understanding of the word 'repetitive' brings to mind the notion of a defence against loss or absence, the indulgence in fantasy and omnipotence. Is that how we are to take up the term 'repetitive', or is this a word used to describe something that is without meaning, non-human? When considering autism, are 'interests' and 'activities' viewed as expressions of desire when the patient does not appear to construct the expected social links via these 'interests' and 'activities'? It is clear that we end up with a definition that does not capture the internal world of an individual. This is a definition of what behaviour looks like when it goes 'wrong', a description of observed failures, a deficit view.

Importantly, capturing the individual's internal world and their experience of that world serves to humanise that individual; however, it is also important to remind ourselves that this is not the only thing that psychoanalytic thinking can provide. In a sense, providing a narrative of acceptance in the absence of understanding lets psychoanalytic thinking 'off the hook'. In the following sections we apply psychoanalytic concepts to the words used in the growingly problematic APA definition of autism in an attempt to capture some of the aspects of how an autistic individual may experience their internal and external world. But first, with all the developments—not psychoanalytically-focused—in the world of neurodiversity, a brief overview of these shifts.

Neurodevelopmental Paradigm Shifts Within Research and Clinical Practice

In *The Neurobiology of Autism* (2005), we are reminded that the field of autism is filled with clinical presentations, sensitivities and symptoms that are not yet fully understood. Current research documents findings across the field rather than suggest finite conclusions. We have also moved into times of understanding neurodevelopmental overlap rather than stand-alone, categorical identification of neurodevelopmental difference (Gilberg, 2021). Thus, we are moving away from a purely medicalised model of neurodevelopmental care.

The neurodiversity-affirming movement encourages us to embrace people with neurodevelopmental differences as having natural variation in human brain functioning. The realm of neurodevelopment is separate to mental health and psychopathology—one does not attend therapy because of autism since autism is not a problem to solve but rather a neurotype to understand; we are not 'treating autism' as if it is a pathology or mental health issue (Axbey et al., 2023). A core condition for therapy to be effective is a therapeutic value of unconditional positive regard. Autistic individuals, like all individuals, value authenticity and empathy (Dempsey & Marsden, 2023). Awareness of one's own neurotype as a therapist prevents the double empathy problem[1] (Milton, 2012). Curiosity and spontaneity are important qualities that build safety, empowerment and self-advocacy—these seem more important than neutrality or abstemious modes of being.

It is helpful, if not a moral imperative, to normalise neurodivergent ways of being that originate in differences in neurology (Dallman et al., 2022). What was previously understood as interrupting the flow of social communication or being quiet or more object-focussed engagement is a valid and acceptable way of engaging, and not as resistance to deeper work (Monteiro, n.d.). The autistic voice should be central—historical power differentials need to be corrected. Epistemic humility needs to replace injustice (Ficker, 2007).

The sensory environment, the consideration of monotropic[2] focus needs, and communication style accommodations are useful considerations when making therapy accessible. Psychoanalysis might be enriched with multidisciplinary input from a neurodiversity-affirming framework where other aspects of functioning are supported (e.g., Dallman et al., 2022).

Another tenet of neurodiversity-affirming therapy is the recognition of value in diversity and examining one's views to see value in living a life that is different or disabled. Capitalism ideals of independence, productivity and unpacking neuronormative goals of therapy are needed (Chapman, 2024). Independence might be enabled by support and not aloneness, for example. Being neurodiversity-affirming also considers neurodivergence in the context of other identity factors such as a person's gender, sexual orientation, experience of culture and stigma, and how these additional factors can make positive neurodivergent identity more nuanced (Walker & Raymaker, 2021).

Compliance-based approaches to therapy (e.g., ABA[3]) are seen as unethical (Milton, 2018)—developing a sense of self is not a behavioural task (Anderson, 2023). There is also a rejection of social skills training that aims to mask difference or disability with the aim of more neurotypical ways of being in the world as preferable (Dallman et al., 2022).

Having introduced some of the shifts in neurodiversity-affirming models of care, we now wrestle with some analytic concepts in clinical encounters through old language and new learnings.

'Deficits' in Social Communication and Interaction

When accounting for deficit it is important to distinguish between what the individual knows or understands and what they are capable of doing with their knowledge and understanding. Deficit can too easily denote some sort of absence or lack and not challenge assumptions about what is not there because of 'its' inherent absence of representation. There are many examples of writing that capture the idea that when it comes to social interaction there are certain things that autistic individuals do not grasp intuitively. Kanner (1943) explained that autism is the consequence of an 'innate inability to form the usual, biologically provided affective contact with people' (p. 250). This is a problematic stance as it disqualifies autistic individuals from engaging in interpersonal relationships based on hidden assumptions of what it means to know something, and what the valid ways are in which such knowing can be acquired and demonstrated.

When the therapist is with an autistic patient who, in certain situations, does not *know* what to say, representing the patient's experience of their *external* world is important, but only captures an aspect of the patient's lived experience. The patient's experience of their *external* world, whether it is of shame, ridicule, boredom or confusion, stands in relation to their experience of their *internal* world. Why do they not know what to say? Is it because of a deficit in the sense that their mind is not producing responses to the conversation, or is it because of a deficit in the sense that their mind produces too many responses to the conversation and that they do not know *which* option to choose? Being specific about what the deficit actually is serves to provide an account of what the patient has to contend with in their experience of who they are in the world. This can be overlooked if the therapist moves too quickly to assist the patient in finding adaptive strategies to navigate

interpersonal situations. When this happens, an opportunity to demonstrate the profound good that psychoanalytic thinking can do is lost.

Psychoanalytic ideas of healthy positions of 'knowing' reference the notion of castration—the idea that what one knows is always in relation to what the other knows, that it is always subject to possible attack or support and that it can function as a way of warding off anxiety around impotence and lack (Dauphin, 2023). When 'knowing' goes wrong, it can result in positions of extreme uncertainty, as expressed by many individuals with anxiety disorders. Obsessive and compulsive behaviour can be understood as experiences of not knowing that are remedied by ritualised acts that facilitate a type of prosthetic knowing. These are only a few examples of psychoanalysis' engagement with the notion of 'not knowing'. The influential texts on these topics (e.g., Freud, 1895; Mander, 2004) are typically characterised by meticulous formulations of the patient's internal world, their personality structure, the defences that they employ, their attachment style and how their very being presents itself via the therapist's countertransference. However, when it comes to autism, this depth of representation of what it is *like* for a specific individual to be autistic and how being autistic structures their internal world gets lost when we rely on diagnostic and descriptive language that represents the individual via the notions of deficit.

Arguably, psychoanalytic thinking has not been developed to determine how much of the autistic individual's experience is to be attributed to their unconscious and psychological structure, and how much of it is the result of neurological structures and the manner in which the different parts of the individual's brain communicate with each other. What psychoanalytic thinking can do is give representation to how the individual experiences their own mind in relation to neurotypically normed notions of what it means and looks like to live in relation to others. This is not a critique of psychological interventions aimed at assisting individual's with autism in finding strategies to help them manage their social engagements, rather it is an exploration of what psychoanalytic thinking can offer in understanding the autistic person. Let's turn our attention to these offerings.

CONSIDERING PSYCHOANALYTIC CONCEPTS WHEN WORKING WITH AUTISM

Countertransference

An investigation of one's own countertransference remains one of the most important practices for a psychoanalytic psychotherapist in the pursuit of understanding their patient. The effects that the patient's influence has on the therapist's unconscious, and the subsequent feelings and thoughts, provides a deep and nuanced sense of the patient's internal world (Freud, 1910). The use of countertransference is also based on the understanding that the patient, including the autistic patient, projects into the therapist. It is problematic and poorly substantiated that some writers suggest that autistic patients display a lack of projection, citing this lack as the primary distinction between autism and psychosis and the likely consequence of

'defective equipment', 'disturbed object relations' or 'primary masochism' (Ribas, 1998). This is an example of how autism can be misunderstood as a form of inherent psychopathology, rather than a different way of thinking, experiencing and relating. It is possible that authors who believe that autistic patients do not use projection fail to adequately interrogate their own countertransference experiences of lack, emptiness and inability, leading to a form of disavowal that leaves the patient having to hold and account for that which the therapist has failed to recognise.

'Disability awakens discomforting feelings' (Watermeyer, 2013, p. 52) in able-bodied people, activating certain psychological defence mechanisms, including projection and projective identification. Autism can be understood as a form of disability since it is a difference. It is well known in disability studies literature that disabled people act as receptacles, consciously and unconsciously for able-bodied people's own feelings about disability (see Watermeyer et al., 2019). Indeed, Shakespeare (1994) called disabled people 'dustbins for disavowal' in the process in which able-bodied people project their unwanted, difficult disability-related emotions into disabled people—the same process may be at play with neurotypical therapists and their autistic patients. Such unwanted feelings are often caught up with shame, dependency, vulnerability (Harvey, 2015): 'disabled people as a group are psychically exploited by the dominant majority, as containers for projection of unwanted human characteristics such as shame and vulnerability' (Watermeyer et al., 2019, p. 517). While this has been written about in relation to visible, physical disabilities, arguably this notion can be applied to the case of invisible disabilities, including autism. Thus, autistic people may act as receptors of other people's projections of disability. Living with otherness 'necessitates a constant conscription with the ascriptions of others' (Watermeyer et al., 2019, p. 519).

The 'Transference and Countertransference' sections in Nancy McWilliam's *Psychoanalytic Diagnosis* (McWilliams, 1994) are crucial components in the diagnostic process. McWilliams focussed on personality organisation and not on neurological structures, she extrapolated from the various components that make up personality and grouped the various psychopathologies that result from maladaptive personality formations. As a form of comparison, it would serve psychoanalytic psychotherapists well to have a similarly well-developed and clinically based understanding of the typical countertransference experiences that the therapist can expect when working with an autistic individual. This would be, in a sense, a vast undertaking as there are so many different components that make up the differences between a neurotypical and a neurodiverse individual. But what if the aim was not to build a library of possibly countertransference experiences that can be used as a checklist for the psychotherapist? What if the aim was rather to remind ourselves of how countertransference works—not only as a way of confirming or excluding certain forms and structures of psychopathology, but that it is also a very powerful direct and indirect way of experiencing and making sense of what it is like to be the patient, to exist in their world?

Many who work with autistic patients hold the view that countertransference-driven endeavours to clarify the 'way in which the patient is autistic' do not account

for the variations in play (Krass, 2020). This multitude of variations can easily lead to confusion for the therapist, ranging from not knowing what the patient is saying or what they mean to not being clear about one's own experience of the patient. Here we are focussing on the therapist's understanding of the patient. The therapist's experience of confusion, specifically as far as diagnosis is concerned, may be an indication that some form of neurodiversity is in play. It is also important to match the therapist's experience of confusion with their reaction to it—the extent to which the therapist may view the patient as unintelligible, or dismiss them as being ill-fitted to a psychoanalytic therapy, as well as the therapist's rigid adherence to partially relevant diagnostic formulations may point to a neurological component in play. We have found that many so-called 'high-functioning' autistic patients present with a history of diagnoses that capture only the *consequences* of undiagnosed and unmanaged autism such as depression, anxiety, relationship difficulties, burnout, withdrawal and substance and medication abuse. Diagnosing only the patient's symptoms in the absence of understanding their subjective experience of the world may serve as welcome relief for the therapist who is struggling with not knowing what to make of their patient. Furthermore, this confusion may well be the consequence of a projection received from a patient who themselves live a life riddled with uncertainty and confusion as they try to navigate an overwhelming amount of variables. Countertransference-driven confusion may also represent a void that could only be filled by certainty, a wish for a type of demonstrable knowing that could quiet an obsessive mind bent on obliterating unpredictability.

The Frame

Concepts such as 'transference' and 'countertransference' are indispensable when trying to get a sense of how a patient relates to the people in their world and how these ways of relating came to be. The analytic frame is used like coordinates on a map to track when there are emotional and relational shifts in the therapist, including the shifts stemming from countertransference. The analytic frame is just as important when working with neurodiverse patients as it is when working with neurotypical patients, but it needs to be in a manner that accounts for the reality of the patient's brain structure.

Saying 'hello' and 'goodbye' at the bookends of any interaction, and the rituals that make up these acts say a lot about the nature of the relationship. The way that the beginning and ending of therapy sessions unfold often can change as the therapy progresses over time, as the nature of the relationship comes to be assumed. Many autistic patients do not display this kind of change, since the beginning and ending of sessions are perpetually experienced as moments of awkwardness. This can leave the therapist feeling that the patient is not connecting with them. It would be presumptuous to decide that a lack of experienced connection with a patient necessarily betrays an attachment disorder, or a lack of need for emotional connection. It should be considered that the patient may well be able to connect on a profound level, but that the representation of the connection may be alien to the neurotypical therapist.

Any experience of emptiness or lack of connection felt by the therapist should be interrogated as a possible countertransference-based reaction to experiencing a lack of the expected gestures, rituals and consequent emotional states understood to be typical in the forming of a psychotherapeutic bond. It is not uncommon for autistic patients to represent the truth of their world and their experiences via verifiable facts and explanations (Gombosi, 1998). This by no means implies that the emotional components are absent. It reveals how difficult it can be for autistic individuals to trust their emotional states, since emotions are variable and often fleeting.

The analytic frame can also become a harsh and pathologising metric when working with neurodiverse patients who, for example, struggle with attentional and time management difficulties leading to chronic lateness for therapy sessions (Sorscher, 2020). No patient is exempt from being oppositional to an activity that is unpredictable and can potentially lead to painful experiences. However, it is important that the psychotherapist continually tries to tease out when they are dealing with defences and when the frame is rendering clear the often unacknowledged and misunderstood difficulties that the autistic patient has to navigate (Sorscher, 2020).

The patient's curiosity about the therapist and about the therapy space, including its contents, needs to be met with initial softness and the therapist's own curiosity. As a result of struggling to trust their own sense of people, autistic patients often rely on gathering information as a way of finding themselves in relation to others (Mayes, 1991). It would be unrealistic to expect an autistic patient to share their inner world and be vulnerable in the absence of this kind of positioning. This is a curiosity that differs from intrusiveness, a defence against being known, or an attempt to take control of the session. Regardless, the therapist may experience it as intrusive, and it is up to them what they share. What is important is that the patient's need to position themselves in relation to the therapist is validated rather than pathologised.

Narcissism or Ways of Existing?

There are certain features that are frequently encountered when working with autistic patients that can potentially leave the therapist with the impression that the patient has a narcissistic personality structure. Much like narcissism, these features have practical functions that allow the patient to navigate their world in a manner that maintains their sense of self as well as their understanding of the world. However, unlike narcissism, these features are not aimed at maintaining the repression of painful memories and threatening representations of the self (Freud, 1913). The importance of making the distinction does not necessarily lie in ruling out narcissism, as autistic patients are not immune to being narcissistic. Making the distinction potentially allows the therapist to know when they are working with an aspect of the patient's self that speaks to personality, and when they are working with the patient's cognitive style.

When a patient has a preference for representing their world and their experiences in a specific manner, it can give the impression that only their version of reality is

valid. This can give the patient a narcissistic feel since they can come across as dismissive of how other people represent reality. It is crucial that the therapist determines what lies behind the need to maintain a particular version of reality. A narcissistic individual is motivated to maintain that their own version of reality is superior—better than the version provided by others (Goodwin & Luchner, 2023). This is a form of triumph; the function of maintaining a particular version is that it perpetuates the patient's sense of potency. However, for the autistic patient, the need for specificity, for correctness, may well indicate a cognitive style which is, firstly, aware of a great number of ways in which reality can be represented. Secondly, the patient may be exhibiting a need for specificity as a way of holding together, maintaining a workable and manageable version of reality (Sorscher, 2020). Naturally, this cognitive style may well be experienced by others as narcissistic, and it may be helpful for the patient to learn this as a way of navigating the world with a more nuanced understanding of how other people experience them.

Narcissism is also about a lack of representation of the experience of the other (Goodwin & Luchner, 2023). Often for the autistic patient, the way in which the other views the world is difficult to represent, rather than that it is implicitly invalid. When considering the presence of narcissism, the therapist needs to determine where the patient's enjoyment lies. For the narcissistic individual, the enjoyment often lies in the triumph over the other; the enjoyment of 'correctness' is essentially relational (Goodwin & Luchner, 2023). For the autistic patient, the enjoyment of correctness more frequently lies in the increased understanding of a matter or concept; in this sense, it is non-relational. It is important that this distinction is not used to further perpetuate the trope that autistic individuals cannot know the minds of others and that they lack empathy. A perceived lack of empathy could become another way in which the patient is misunderstood as narcissistic.

Benvenuto (2019) exhibited an example of this kind of misunderstanding when he linked the often referenced perceived lack of empathy in individuals with autism to a kind of lack of knowing to their perception of the subjectivity of others. Here, the lack can denote an emptiness, an absence, where the autistic individual may well be contending with an over-abundance of possible versions of both their own subjectivity as well as the subjectivity of the other, leaving them with no clear way of 'knowing' what the other may be experiencing. When considering the matter of empathy in individuals with autism, it is also important to clarify the type of 'knowing' underpinning the empathy supposedly exhibited by neurotypical individuals. When a neurotypical individual expresses empathy, are we to assume that, in doing so, they are truly referencing the subjective experience of the other? (Phillips & Taylor, 2009). It may well be that autistic individuals are less frequently engaged in a social game of demonstrating that they are being a 'good person' and that this lack of play can be viewed as a lack of caring.

Intellectualisation or Spaces of Representation?

A psychoanalytic understanding of intellectualisation is that it is a defence (McWilliams, 1994). This may seem an obvious point not worth stating. However,

it is possible to use the function of intellectualisation in a manner which does not defend against the experience of or representation of affect (Akhtar, 2009). Autistic patients often represent their world and their experiences in intellectual terms, which can give the therapist the impression that the patient is intellectualising in a defensive manner. It is important to understand why autistic patients tend to rely on intellectual representation of their reality. A neurotypical understanding of autism often includes the notion that there are certain unspoken and nuanced elements of communication and relating that are missed by the autistic individual. These elements can be thought of as unconscious and unspoken assumptions about the rules of engagement. In a sense, it allows for a state of relating that is based on the understanding that, unless one is confronted by a clear problem or difficulty, 'everything is fine'. In a simplified sense neurotypical individuals benefit from these assumptions insofar as they only have to spend mental energy on *what is*. Autistic individuals on the other hand tend to spend a lot of mental energy on *what could be*. This is not necessarily an anxiety-driven endeavour, although it can result in anxiety. Rather it is an attempt to keep up with and represent everything that the mind becomes aware of—a mind that struggles to curate information, if something is relevant and related it will be included in the representation of reality. With such an overwhelming amount of information and the variety of ways in which the various elements can be constellated, a nuanced and specific intellectual representation of reality is crucial. Indeed, this dynamic is in the service of becoming anxious and overwhelmed in much the same way as we would expect to discover in a defensively intellectual patient. The difference is that the autistic individual's anxiety is inevitable as a result of a lack of control over how much information their mind takes in and confronts them with—it is a functional dynamic, it is not defensive.

Rather than misunderstanding this phenomenon as an 'autistic defence' and trying to get an autistic patient to relinquish their intellectual representations, the therapist should allow for these much-needed and often highly creative and sophisticated intellectual structures (Cohen & Jay, 1996). We have found that, with many autistic patients, the patient is quite undefended and able to engage the emotional components of their experiences, or the experiences of others, if these affective states can be considered in relation to the patient's intellectual representation. When considering a patient with poor organisational skills, lowered processing speed, repeated experiences of academic failure and an environment that fails to understand why the patient is not capable of demonstrating their understanding in a typical manner, the therapist may well be dealing with the patient's idealisation of 'knowing' not as a shiny object to be worn with pride, but rather as an intellectual wheelchair that would make life bearable.

Obsessions or Spaces of Knowing?

A significant percentage of individuals with autism exhibit obsessive behaviour (Russel et al., 2005), or rather exhibit *behaviour* that could easily be misunderstood as obsessive in the classic psychoanalytic sense—behaviour that betrays a relation to repressed elements (Freud, 1896, 1936). However, when we refer to autism as an

obsessional disorder, we are in the realm of nosologically determined statements that carry etiological implications (Meltzer, 1975).

When a therapist is confronted with interests and behaviours in their patient that suggest exaggerated focus on objects and topics, various forms of repetition and apparently rigid approaches, they need to ask—what is the function of the behaviour? To say that the behaviour manages anxiety is not enough to determine that we are in the realm of obsessional dynamics. In order to define the behaviour as obsessional, it needs to be established that the patient is driven by an unconscious need to exercise omnipotent control over their external objects, in the service of control over potentially overwhelming internal objects (Meltzer, 1975). Here we are in the realm of magical thinking, of linking unrelated elements in reality in a manner that provides the individual with a demonstrable and repeatable act of control. Washing one's hands five times each morning before 5:00 am to protect one's mother from brain cancer would demonstrate this dynamic.

For the autistic patient, repetitive and hyper-focused behaviour potentially provides a very different function. We retain the word *obsession* in italics when referring to autistic individuals. We have found that for autistic patients, *obsessions* cannot be displaced; the object of the obsession is not unconsciously selected as it does not exist in the service of repressed elements (Freud, 1917). Rather, *obsessions* are specific in two different senses that speak to two different functions. Firstly, they are specific in that they are consistent and verifiable. Meticulous timekeeping and punctuality would be an example. This *obsession* can extend to an *obsession* with watches and clocks, and calendars. The function of this *obsession* is that it structures reality. An autistic individual who is acutely aware of all the variable ways in which a given day might unfold, who feels compelled to account for every possible eventuality—not as a result of anxiety, but as a result of a cognitive style that does not filter out external information—might find stability and relief in the notion of predetermined times for events.

Secondly, autistic *obsessions* are specific in that they mirror aspects of the individual's internal world, of their sense of self. When the autistic individual is engaged with the chosen object/activity they have a mix of experiences that includes a confirmation of 'this is me'. Herein lies the function of these types of *obsession*, they confirm and maintain for the individual a kind of proof of their subjectivity. We can define subjectivity as a social construction, based on language, mediated by social interaction (Frie, 1997). To expand on this concept we will use Ogden's (1985, p. 131) view of subjectivity:

> Subjectivity is a capacity for a gradient of degrees of self-awareness ranging from intentional self-reflection to the most subtle, unobtrusive sense of 'I-ness' by which experience is subtly endowed with the quality that one is thinking one's thoughts and feeling one's feelings as opposed to living in a state of reflexive reactivity. Subjectivity is related to, but not the same as, consciousness. The experience of consciousness (and unconsciousness) follows from the achievement of subjectivity. Subjectivity is a reflection of the differentiation of symbol, symbolized and interpreting subject.

Social interactions and interpersonal relationships play determining roles in the establishment of an individual's subjectivity, in terms of the nature of the subjectivity (the specifics of the individual—good and bad), and how the individual's subjectivity is represented and understood. When reflecting on Ogden's (1985) definition we are reminded of the complexities and nuances of subjectivity. We are also reminded that subjectivity is an achievement—something that the individual needs to 'get right' in relation to others, something that can consistently (in the good enough sense) and reliably be replicated. If an autistic individual stands outside of the assumed social norms that would typically mediate this process, it places them in a precarious position as social interactions become essentially unpredictable. It is possible that, for the autistic individual, a strong interest in and repetitive return to a specific object or area of interest also provides a sense of self. The use of 'autistic objects' regulates anxiety for the individual because the object is stable, predictable, specific and imbued with significance and a history of a form of relating (Dergicz, 2019). Fixations can provide a strong sense of meaning (Grandin, 1996). For the neurotypical individual, the 'use' of relational spaces can also manage anxiety precisely because it affirms a sense of self. It is not enough to focus on the function of seemingly obsessive tendencies, one needs to cultivate a sense of how the patient's subjectivity is structured and maintained by the obsession. Approaches adopted by those who claim, as Baron-Cohen (1989) does, that obsessive behaviour exhibited by autistic individuals do not meet the criteria for an obsessive-compulsive diagnosis because these individuals are incapable of reflecting on their own mentals states completely disregard the individual's subjectivity.

We must not miss the relational element in the autistic individual's use of objects. The crucial role that this type of relating plays in maintaining the autistic individual's subjectivity may well explain why it can become obsessive—in the sense that it reveals an intensity and desperation.

We are not saying that *obsessions* are healthier than obsessions. Both come at a cost, and both offer specific services. An autistic individual who is *obsessively* punctual would certainly benefit from understanding that others may not be able or willing to align with their take on time as an element that structures reality. We also acknowledge that the two categories may well overlap, as an autistic individual still has an unconscious and the ability to repress.

CONCLUSION

This paper represents an attempt to develop a conversation about psychoanalytic psychotherapy and autism—a conversation which [re]positions the psychoanalytic method as a way of being curious, a way of suspending one's theoretically based assumptions about attachment, communication, relating and being. It is a conversation which invites the valuable input from the realm of neurology, the very realm from which Freud emerged. Accordingly, the aim is to affirm rather than pathologise ways of being that autistic patients present with. We have tendered some thoughts on what it is like to sit with an autistic individual in the

psychotherapy room and be curious about their subjectivity. There are many other ways autistic clients might be misunderstood and we acknowledge that this is the beginning of a conversation. It is no easy task to find the balance between holding on to key theoretical concepts and allowing for new unexpected understanding. We believe that working psychoanalytically with autism is a call to do just that.

ENDNOTES

1. A break down in mutual understanding between people with different communication styles. Historically this was seen as a communication problem due to the neurodivergent person's difference rather than due to an interpersonal and mutual issue that occurs between an autistic and non-autistic person (Milton et al., 2022).
2. The way an individual may prefer to focus on a single/smaller range of interests at a time; attention is more concentrated.
3. Applied Behavioural Analysis: radical behaviourist philosophy historically using theories of learning to alter behaviour to be more in line with developmental norms.

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