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The application of Esther Bick's method to the observation of babies at risk of autism

Pierre Delion

Abstract

The author describes the creation of a multi-disciplinary service for the early detection and treatment of babies at risk of autism. Necessary steps included cross-disciplinary training and regular multi-disciplinary case conferences. The use of infant observation in psychiatric interviews, as an integral part of the diagnostic process, is discussed. Examples are given of the way such observations can serve at the same time as an aid to diagnosis and as an early intervention.

Key words: autism, early intervention, infant observation, transgenerational issues, trauma, multi-disciplinary co-operation.

The structure of the service

In the Département of Maine et Loire, the concerns of two main professional disciplines has led to increased attention being paid to babies who seem at risk of developing autistic features. Firstly, the paediatricians in charge of the Département's Centre for Early Medico-Social Intervention [Centre d'Action Médico-Sociale Précoce, CAMSP], were in the position of picking up babies at risk of autism whom they then encountered difficulties in placing with the local child psychiatric teams. Secondly, the child psychiatrists and their teams found it distressing to be referred children with autism at too late an age, at a point when the autistic process had already led to symptoms and behaviour becoming entrenched.

In order to establish useful links between paediatric and child psychiatric services, the psychiatric teams had to be prepared to change in a way that made it possible for them to treat babies at risk of autism according to criteria presently agreed by specialists in that field. This meant that the child psychiatric teams needed to undergo training in several areas: a specific training in the psychopathology of autism and appropriate methods of treatment; training in infant development, designed to equip workers to treat babies who had relationship problems; and training in infant observation according to the method of Esther Bick (1968), an opportunity which was

offered to some volunteers from the various teams in the Département dealing with children with autism. In parallel with this, CAMSP paediatricians familiarised members of the child psychiatry teams with the specialised work of paediatric neurologists, geneticists, neonatal specialists, and so on.

Obviously, this training led to changes in the way each service was organised, in order to make it possible to offer intensive and specific early intervention to babies at risk of autism. Workers are able to offer prolonged and intensive specialist intervention, and to make themselves available for two or three appointments each week.

After a meeting between paediatric and child psychiatry teams concerned with this problem of public health (the CAMSP, the paediatric neurology service, and one of the child and infant psychiatry teams particularly concerned with the problem of autism), it was decided to formalise regular monthly meetings for the purpose of discussing the shared work. These discussions gradually led to outlining the stages of detection, assessment and referral. A paediatrician working at the CAMSP who encounters symptoms suggestive of a risk of autism will consult the child psychiatrist and different members of the CAMSP paediatric team with regard to assessment and treatment possibilities. It is suggested to the parents that an assessment of the EEG should be carried out, as well as of metabolic, genetic, radiological and other factors. Finally, a child psychiatrist trained in Esther Bick's method carries out an infant observation, which is provided in the paediatric neurology service. (In the second part of this paper, I shall present examples of such observations).

Discussion at multidisciplinary meetings leads to a formulation, after which a CAMSP paediatrician sees the parents with their baby to suggest a treatment plan. The question of a diagnosis of autism is often raised at this point, as we find that more and more parents have become aware of possible indications through the media. The parents are offered an appointment with the local child psychiatrist, in order to facilitate the move from the CAMSP, who provide support at this critical stage, to the psychiatric team which will devise an intensive treatment plan, adapted to the needs of each individual baby, as near to the parents' home as possible. The parents may be offered other interventions, whether by a Centre Médico-Psycho-Pédagogique or by a child psychiatrist; in these cases, efforts are made to ensure that such interventions complement those of the district team.

This procedure is now clear and in place, but all the working partners had to make deliberate efforts to make this possible. The district teams had to collaborate to translate these principles of prevention and intervention into action. They had to debate a question central to their own structure: should one team specialise in this work, or should all teams be organised in such a way as to be able to respond effectively to the needs of babies as near as possible to where they lived? We opted for the second alternative, and an Autism Federation was formed with the aim of co-ordinating the efforts of the four teams of child and infant psychiatry in the Département, and of promoting the sharing of experiences with babies at risk of autism, and the development of structures for training and research.

Recently, we have formed an association (Dépist-Autisme) to publicise our service to anyone concerned with infantile autism, and to promote our aim of detecting babies at risk of developing autistic features. This aim grows out of our shared conviction

that the prompt discovery of signs of risk, followed by early and sustained specialist intervention, can considerably modify the fate of the baby concerned. The executive body of the association is made up of professionals, doctors, administrators and parents. We provide lectures and training for GPs, paediatricians and professionals concerned with babies and toddlers, as well information for the general public.

The establishment of these links across professions and services means that we see children as young as one year old, which has meant considerable changes in our practice. For example, we suggest to parents that, once the stage of major anxieties in the child concerning bodily integrity has been to some extent overcome, they should work towards helping him or her to settle in an age-appropriate educational setting, whether this is a crèche, a nursery school, or a special placement. This means that the parents retain their special position, while therapists and teachers each perform their own specialist function. All members of the working partnership meet together regularly: this allows us to support the specific nature of each member's contribution, while ensuring that they complement each other.

The nature of the therapeutic alliance with the parents is of particular interest. Our assessment and treatment procedures are based on a logical approach to the problem of autism, and on the central importance of seeing the baby as a person. We keep the parents informed of the results of all investigations as these come in. This means that parents can often understand psychiatric treatment to be the appropriate response to facts which we have elucidated in partnership with them during the assessment. Sometimes this is not the case, for example when parents have adapted in such a way as to mask their child's problems. Even in these situations, the links between professionals help them to support the parents, and to modify their refusal to acknowledge the reality of the child's condition.

There is no doubt that the parents of a child with autism, as well as the child, formerly faced something of an obstacle course in the search for appropriate treatment, which could leave them seriously bruised. Parents often speak about the gap between diagnosis and treatment as though it were a 'black hole' of despair into which the child and family were plunged. Realising the importance of this unacceptable fact gave us the energy necessary to make the far-reaching changes in our approach to babies at risk of autism which I have described.

Examples of infant observation in the assessment of babies at risk of autism

a. Observation of Quentin

I was asked to see Quentin and his mother in the context of an assessment for autism in the paediatric neurology service. While the nurse fetched Quentin from his room, his mother explained that he had developed normally until the age of ten months. At that age he began to turn away from people and to avoid eye contact with his parents. Instead he gazed at his hands, which he rotated incessantly in stereotyped movements. He howled night and day in a monotonous voice, and often lay on his

back and performed stereotyped movements with his rigid arms and legs. He would spread his legs apart, stiffen his arms, rest his hands on the floor, and bang his head against it sufficiently hard to bruise his forehead. His muscle tone had deteriorated markedly; he fluctuated between the complete lack of tone of a 'bag of sand' and the excessive rigidity of an 'ironing board'. When he was in this rigid state he would try to bite his mother. His parents consulted their GP, who sent the family for assessment.

Quentin aged eighteen months

The nurse comes into the playroom of the paediatric neurology service, and puts Quentin down on the carpet. His mother doesn't move: she seems exhausted. Quentin cries in a monotonous wail: he makes attempts to hold out his arms towards his mother, but she clearly fails to see this, as she is talking to me and seems to find it difficult to attend to Quentin at the same time, at least at this early stage of the interview. Quentin's crying conveys despair to me. His mother now becomes aware of her baby, turns towards him and picks him up, but Quentin instantly contracts his muscles into a state of hypertonicity with legs extended and his arms pulling at his mother's neck and hair. He manages to hoist himself up her body and tries to bite her neck. She pushes him away slightly, looking at him with an anguished expression. The lack of balance in Quentin's muscle tone suggests defences organised around pathological clinging, with hair pulling and attempts at biting, as well as the establishment of anxiety-laden relationships.

There follows a moment of isolation: Quentin has turned towards the window. He is uttering no words or even noises, but is actively turning his back on us.

At this point, mother tells me that, when Quentin was ten months old, it seemed that his developmental continuity was shattered. 'Nothing actually happened, but...his Daddy, who spent a lot of time with him after work, became seriously depressed....' She was silent for a few moments. 'Oh yes, it's true, it was just at that time, and not just any ordinary depression, either. His Daddy works in the slate mines, and he was down the mine with a colleague he was friends with. He had to do something else for a minute while his colleague started up a slate-breaking machine that wasn't working properly. When he came back, he found his friend being dragged into the machine, and when he tried to pull him out, all his friend's organs spilled out in front of him, and he thought it was he who had killed him. I've spoken to the doctor at the mine and he told me that the man was dead before Quentin's Daddy found him, and certainly before he did anything.'

While she tells this story, Quentin's mummy weeps abundantly, and Quentin turns towards her, looks at her, then at me and holds out his arms. She picks him up, saying, 'My baby'. A transformation takes place before my eyes: from now on, Quentin is with us. Looking at me, he throws me a round plastic toy which I throw back to him: he returns it to me, I reciprocate, and the next time around I include mother by handing her the toy so that she can throw it to Quentin. She smiles and he smiles back; emotional attunement has been re-established. I point this out to mother, who weeps again, overflowing with emotion as it seems to me. Quentin interrupts his play and looks at his mother with full communicative intent. He holds out his arms to her and she picks him up, saying, 'I've found you again, Quentin'. She weeps again and he begins to flap his hands in a somewhat stereotyped movement. She moves him away from her and he cries a little, showing by the way he holds his body that he wants to go on the carpet. Once there, he balances on his bottom and rotates his hands and feet. She looks at him with an expression of some disappointment but complete involvement. Quentin continues to look at her and lowers his two legs, which he had been extending into space, to the carpet. He looks at me, picks up the toy we had been using, and throws it to me with his right hand. His left hand continues to rotate, then comes to rest on the carpet, and the three of us play as before.

Mother says, 'It's as though he were overflowing with his feelings and didn't know what to do with them, so he has to evacuate them.' Quentin looks straight at me and says, 'Daddy'; and mother responds calmly, 'You're playing with the doctor just *like* the way you did with Daddy.'

After a long silence full of feeling, I comment: 'Quentin has a lot of problems, but he also has a good capacity for opening up, thanks to his mummy's emotional support. We're going to have a doctors' meeting to compare the results of all the investigations, and then we'll offer you an appointment to let you know the result of our assessment, and well as our suggestions for a programme of therapy to help Quentin.'

After our case conference, we suggested that the parents of this baby at risk of autism should get in touch with the child psychiatry team closest to their home. If they agreed, we would pass on the outcome of our assessment to this team, with whom we were in regular contact. The parents wished to proceed, so it was possible to offer Quentin intensive early intervention on an outpatient basis. Events proved that the diagnosis of autism was justified, but that he had important capacities for development.

b. Observation of Marion

Marion was eighteen months old when I met her and her family. She was referred for a consultation within the paediatric neurology service by the paediatrician who had looked after her since her discharge from the neonatal service, where she had been hospitalised for six months suffering from Pierre Robin Syndrome (incomplete development of the tongue). This was operated on very early, which meant that she had to be tube-fed from the first days of her life. Her mother presented in a state of hypomanic excitement; her father wondered what point there was in his talking to a child psychiatrist.

Marion aged eighteen months

Marion's mother sets her down carefully on the carpet of the consulting room. Marion lets herself flop, burying her face in a dirty bit of blue blanket. After a few moments, she raises herself up, resting on her head and two legs, with her arms on either side of her torso, like two stabilisers that would stop her from tipping sideways. She emits a cry, first plaintively and monotonously, but soon it becomes sharper and more penetrating. Mother says that this is Marion's favourite position: she's being a giraffe. Marion looks through her legs at her mother, and stops vocalising: step by step, she moves her legs, turning her buttocks towards me. While doing this, she turns her gaze in my direction as well, looking through her legs, but I do not feel that Marion is looking at me. At the very most, she is peeking out of the corner of her eye. Father seems to be overwhelmed with boredom: he sighs all the way through his wife's account of the beginnings of their daughter's life. 'When Marion was born, she was truly a little blonde angel. Then I gave her the breast, and I could feel that she wasn't latching on. I said to myself that perhaps she was too little to suck properly; but then later, as soon as she started to drink, she choked'. Mother is very moved at this point, and father seems more in touch with what she is saying. Marion has let herself fall on her right side, quite gently, as though she were deflating. Mother continues in a trembling voice, 'They took her away very quickly because I was screaming like a madwoman, I really thought she was dead, her little body was all soft, and in just a moment she had turned black. I can't properly remember how long it lasted, I called again, my husband had gone into the corridor to find out what

was going on and I was all alone, I was crying, I thought she was dead.' Father, who suddenly is also extremely moved, says, 'They said they had to suck out the liquid, that some milk had gone down her windpipe, that her heart had stopped beating...' At this point, mother begins to sob, 'you know, it's a year and a half ago now, and it feels as though it were yesterday, I just can't get over it.' Marion gets back into her giraffe position, and turns her buttocks and her glance in her mother's direction. Mother looks at Marion who is moving her legs towards her, and says, 'you see, Marion, mummy nearly killed you.' I say, 'you offered her the breast so that she should live: you weren't in a position to know what would happen.' She looks at her husband and says to him, 'yes, you've said that to me as well, but I can't help it, I still believe it.' Marion turns towards her daddy and rests her buttocks against his knees. He lifts her up and she strains away from him, stretching out her neck and rotating her head. He stands her in front of my desk and says to her, 'come on, say something to the doctor.' Marion clings with her hands to the edge of my desk; she allows them to slide a little, then catches hold of the edge with her teeth and holds onto the desk by means of her jaws alone. Her daddy comments, 'this is how she's been holding herself up since a few days, with her teeth. You've seen what she does with her arms, there's no way of getting her to walk, she just backs away.' Marion continues to clamp onto the edge of the desk with her teeth: her arms are hanging down alongside her, and her legs are tensed. Then mother calls to her in a voice full of tears and Marion allows herself to fall onto her bottom in a reasonably controlled way. Mother says to her daughter, 'the paediatrician said you needed to be seen by a child psychiatrist'; then to me, 'what do you think of her, doctor?' I say to the parents that Marion could certainly use some help, but that she also needs the participation of her parents, who at the moment are the only people who know her well enough to help us make contact with her. I also say that the team for their district is my team, and that we can start treating Marion as soon as the parents let us know. Father says, 'well, as for me, I agree right now.' I answer that I would prefer them to talk it over, and to ring us in a week to make another appointment. Mother writes our address and telephone number on a bit of paper in Marion's vaccination record. She wipes her eyes as she puts Marion's coat on, and says, 'I'm sorry I cried like that, I wouldn't have thought...' Marion co-operates reasonably well; then she hits her right eye with the nail of one of her right-hand fingers. Mother is a bit surprised, then thinks of her own tears, 'you want to cry with me, Marion, is that it?' With this rather sad exchange, we say goodbye.

Our team has looked after Marion for some years now. Her body image is much improved and her archaic terrors have receded. We have even begun to collaborate with the Medical Educational Institute where Marion goes to school. All interventions have taken place in close co-operation with the parents.

c. Observation of Mustapha

This little boy came for an assessment at the age of fifteen months; the referring paediatric neurologist thought that he showed signs of being at risk of autism.

Mustapha aged fifteen months

During this observation, Mustapha remains standing motionless for a long time in front of the window, holding a big white handkerchief between his front teeth. His arms are motionless as well, hanging down by his side. Occasionally his right arm makes some tentative movements towards the window, but ends up falling back heavily by his side.

Mustapha's mother tells me that she arrived from Africa two years ago, and that Mustapha was born in France. His father stayed behind, and mother does not explain the reasons

for this separation. The birth went well until Mustapha's head had come out. Then, his arm did not come out properly. Mother begins to cry. Mustapha slightly raises his right arm toward the horizontal, lets the handkerchief fall out of his mouth, and he pokes his tongue out repeatedly, in a very lively way, towards the left. He does not turn towards his mother. She says, 'I lost consciousness, and when I came round, the nurse told me that Mustapha' — and again she weeps abundantly — 'would never be able to use his left arm. He has a paralysis of the left brachial plexus because of the forceps delivery.'

Mother is still sad. She says, 'His arm was operated on, but the surgeon said that Mustapha can't understand anything, so the operation won't do him any good.'

Then she says, in a more resonant voice, 'When Dr. P. told me that on top of that, Mustapha might have autism, then I really cracked up.' She begins to cry again, but this time, Mustapha replaces the handkerchief in his mouth and begins to make a continuous, low, monotonous sound. He holds the lower edge of the handkerchief in his right hand, and accompanies this poor melody with rhythmical arm movements. Mother says, 'the thing I'm most sad about is that when I talk to him, he doesn't listen, it's as though I didn't exist. And the doctor did check his ears, there's nothing wrong.' As though she wanted me to witness what she meant, she gets up and calls her son, 'Mustapha, Mustapha'; then gives me a despairing glance: 'you'll see', and leaves the consulting room. For a moment, Mustapha does not move; then, when I call him, he turns towards me infinitely slowly; his glance takes a few moments to find me. Then, just as slowly, he 'sticks' himself even more closely against the window, and is gone again. Mother comes back and says, 'you see, doctor, he doesn't know me.'

The rest of the interview reveals more about the little boy's history. After a case conference, we agree that he could benefit from a therapeutic observation [according to the method of Didier Houzel, (1989)] by an observer trained in Bick's method of infant observation. Later, additional interventions mean that Mustapha's appointments are increased to four times weekly. His development, including the use of his left arm, showed him progressively coming out of his autistic state. He has been accepted for education in a Medical Educational Institute.

In conclusion, it is my belief that observations carried out in the course of diagnostic interviews with babies at risk of autism constitute a most valuable application of Bick's method of infant observation. This method allows one to explore the baby's symptomatology, but also to investigate the present quality of his interactions and to make links between pathological symptoms, the baby's internal world, and the family history.

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