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Loneliness and Silence in Autism - Implications for Psychotherapy

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1. Introduction

The aim of the following chapter is to present the two phenomena (loneliness and silence) that can be seen in the autistics and non-autistic subjects. At first there were presented characteristics of each of the mentioned experiences. The main hypothesis in the psychotherapy with subject suffering from autism is connected with the existence of the healthy and disordered part of the personality. The therapist should refer to the healthy part and make efforts to find the meaning of the observed pathological symptoms.
This content shows a phenomenological description of loneliness and silence and theirs connections with autism. It also considers how these two phenomena might influence the treatment.
The notion "autism" was used for the first time by E. Bleur in the beginning of the 20th century. The name originates from the Greek word "autos' (alone) and refers to the psychopathological tendency of turning away from the outside world and focusing on the inner world. Initially, autism was treated as the result of or a part of schizophrenic detachment. The term 'autism' entered the official classification in 1943, when Leo Kanner used it to describe a disorder whose primarily feature was the significant abnormalities of social, cognitive and behavioral function in a few children (APA, 1994; WHO, 2000).
The short description of autism indicates the importance of the loneliness seen as a behavioral factor noticed by the researchers.

2. Phenomenon of loneliness

Loneliness is a phenomenon perfectly known to every human being. It is a universal, subjective and difficult to articulate sensation typically associated with negative emotions. Yet loneliness can take the shape of solitude and the positive aspects should not be underestimated. It enables humans to reflect upon themselves, their lives and the surrounding world. Undoubtedly, a significant intensity of loneliness/ solitude leads to physical (Hawkley&Cacioppo, 2010) and mental (Heinrich& Gullone, 2006) dysfunctions. In social understanding loneliness is perceived as a pejorative phenomenon and only unwillingly is it acknowledged by the lonely person. He or she usually fears being stigmatized and becoming a social outcast with the label of a scapegoat or a failure.
Consequently, loneliness is often accompanied by shame and remorse (Dill&Anderson, 1999). In his analysis of the literature, Rotenberg enumerates two elements of loneliness: 1).

cognitive, referring to the disparity between the desired and real social relations in respect to quantity and quality, and 2) affective, highlighting the negative experience of being disoriented, lonely and lost (Rotenberg, 1999).

2.1 Definition

Researchers have not arrived at a coherent definition concerning loneliness. Generally, they distinguish two approaches to the phenomenon: 1) social needs theory and 2) cognitive process theory. The first approach represented by Bowlby, Sullivan and Weiss defines loneliness as a *response to a relational deficit that gives rise to a learning for the insufficient relationship* (Terrel-Deutsch, 1999, p.11). It underlines the human need of social relationships as a means for proper emotional and physical development. Here, loneliness is perceived affectively. The second approach, the cognitive process theory, developed by Peplau and Perlman, focuses on analyzing loneliness from the inner perspective. This theory revolves around cognition and the social relations of an individual. It defines loneliness as a lack of satisfaction resulting from an insufficient network of social relations. There are two factors which may be responsible for such a situation. The first one is the changes within the interpersonal relations of an individual and the second is the changes in the desired, or expected social relations (Terrell-Duetsch, 1999).

A slightly different definition of loneliness, rooted in the philosophical approach, was given by McGraw. He claimed: *loneliness pertains primarily to desired but unattained personal or personified relationships for which one yearns; secondarily, to the absence of current relationships which one misses; and, tertiarily, to the loss of past relationships which one mourns or grieves. Furthermore, the lack or loss of such relationships refers principally to a defectiveness in their quality and, in a subsidiary manner, to a deficit in their quality. (…) Loneliness is a deficiency of the needs and metaneeds of intimacy/meaning, specifically of that kind of intimacy which is meaningful and of that kind of meaning which is intimate* (McGraw,1995, p.44).

The above definition indicates that in order to avoid the negative experience associated with loneliness, the person's metaneeds should be fulfilled.

2.2 Types of loneliness

One of the most known typologies of loneliness was created by Weiss who described it as the most distressful experience in a human life. He distinguished two subcategories of loneliness: emotional and social. According to him emotional loneliness appears when a person undergoes lack of a close emotional relation with another human being. Consequently, anxiety and isolation appear which can be overcome only by the establishment of a new relationship involving attachment. Social loneliness, as Weiss referred to it, is caused by the lack of the network of social relations. It mainly influences people who enter a new and unknown social environment, and have not created the typical network of relations yet. A possible solution to the problem of social loneliness is the involvement in friendships enabling social interactions (Weiss, 1985).

Basing on the time criterion, Young subdivided loneliness into: short-term, incidental, situational and chronic loneliness. These subcategories may all be conditioned by subjective personal characteristics, measured with the Eysenck Personality Questionnaire (Young, 1978 cited in: Hojat, 1983). Short-term loneliness can be experienced by everybody as a reaction to the occurrence of an undesirable event in the life of every human being. Chronic loneliness

is linked with such personal characteristics as: elevated neuroticism and anxiety, introversion, low self-esteem, low level of openness, increased depressive mood, and external locus of control (Hojat, 1982).

Some researchers examining loneliness indicate the necessity of a clear-cut division between pathological type of loneliness and the common type known to every human being (Moustakas, 1961; Booth, 1997). Pathological loneliness may endanger human health, and especially mental health. It originates in existential loneliness exhibited by all people and closely connected with human sense of fundamental emptiness and disconnectedness as well as the consciousness of the unknown, the feeling of transience, and the inevitability of death (Booth, 1997).

Applebaum's psychodynamic approach to the phenomenon of loneliness is based on the feeling of loss caused by the process of separation-individuation (Applebaum, 1978). She indicated 4 types of loneliness: 1) existential, 2) reactive, 3) pervasive nonspecific and 4) psychotic. The first category that is existential loneliness, results in a process of individuation and differentiation leading to a greater degree of autonomy and independent functioning. The second type, the reactive loneliness, appears in response to specific loss. As Applebaum notices:

It can include lonely reactions to any recent loss, as those endured during enforced physical isolation, separation from loved ones, loss of a body part, loss of self-esteem, loss of a vocation or avocation, loss of fantasy, or loss of attachment figures for any reason or cause (Applebaum, 1978, p.17). The third category of loneliness, namely, pervasive nonspecific, refers to people capable of creating social relations but whose dysfunctional habits influence the formation of these relations. According to Applebaum, this category consists of neurotics and people suffering from personality disorders, and particularly those presenting borderline personality disorder (BPD). The key characteristics of psychotic loneliness are: prolonged regression to the unity of infancy and primary narcissism. It can be defined as specific vulnerability typical for schizophrenic patients. The main feature distinguishing psychotic loneliness from all the other types is its degree, duration and defenses.

A very interesting idea of loneliness was put forward by John McGraw who, reaching for its philosophical sources, subdivided it into 10 categories: 1) metaphysical, 2) epistemological, 3) communicative, 4) ontological (or intrapersonal), 5) ethical (or moral), 6) existential, 7) emotional (linked with love and sexual instinct), 8) social (linked with friendship), 9) cultural and 10) cosmic (McGraw, 1995).

All the aboved mentioned forms of loneliness affect healthy people with no mental disorders. The classification is cited to indicate the significance of the phenomenon of loneliness, also observed in patients with the Autistic Spectrum Disorders.

McGraw claims that all types of loneliness emerge from the metaphysical loneliness (1). He states: *it denotes the lack of intimate/ meaningful solidarity with other beings and bespeaks an entitative-emotional longing for their plenitude and connectedness* (McGraw, 1995, p.46). This type of loneliness arises from the consciousness of individual distinctiveness from others resulting in insecurity and instability. Seemingly, it can be compared with the psychodynamic type of loneliness. The core of the epistemological loneliness (2) is defined by McGraw as following: *one is too close to one's self to intimately grasp the self and too far from others to know or be known by them, with the result that such knowledge is ephemeral and superficial* (McGraw,1995, p.50). This assumption postulates the incapability of knowing profoundly both oneself and other human beings.

Communicative loneliness (3) consists of 3 subcategories. The first occurs in reaction to the inability to communicate effectively with others because of inadequate social skills, communicative deficits or lack of social intelligence. The second subcategory of communicative loneliness refers to the failure to develop relationships with desired intimates. The last subcategory designates the incompetence to express negative or self-devaluating emotions connected with isolation resulting in all types of loneliness.
Ontological loneliness (intrapersonal) (4) *is felt threat to obtaining or maintaining self identity and self-integrity, a menace that occurs due to a deficiency of intimacy/meaning which the self seeks within itself* (McGraw,1995, p.53). This type of loneliness is caused by the absence of *the desired other*.
Ethical (moral) loneliness (5) is defined as: *loneliness inherent in freedom, choice and responsibility as well as in value formation, enactment and commitment. It entails the formidable moral task of facing one's loneliness in its diverse forms and of converting it into ethically constructive attitudes and actions* (McGraw, 1995, p.55). Such description of loneliness can also be found in Sartre.
Existential loneliness (6) *is found in the inevitable ruptures of intimacy/meaning within the separate self as it journeys by way of its individuation and socialization through its checkered history of involution / evolution and disintegration / integration* (McGraw, 1995, p.57). This form of loneliness is the most frequent in the so-called *Jasperian* "borderline situation," a situation of radical "*loneliness*".
Emotional loneliness (7), according to McGraw's typology, refers to the physical lack of sexual partner or a person we can feel emotionally attached to. Whereas social loneliness (8) is prescribed to experienced lack of company, friendship or sense of community. The two types of loneliness are borrowed from classification created by Weiss.
Cultural loneliness (9) appears in the case of the lack of the sense of belonging to the mainstream society. It affects people disconnected from the surrounding society. This type of loneliness is typically characterized by lack of cohesion or identity and individuals suffering from cultural loneliness are often perceived as outsiders. Consequently, they may develop an alternative subgroup or 'tribe' of a negative identity.
People sensing cosmic loneliness (10) are under the impression that there is no human being or force, they can refer to or identify with. It is a feeling of a complete and universal loneliness. A sufferer of cosmic loneliness sees the world as unfriendly and hostile and unable to fulfill human needs, and especially emotional needs.

2.3 Developmental stages and loneliness

According to Moustakas' theory, loneliness is the main force motivating human actions (Moustakas, 1961). In order to avoid being lonely and protect themselves from helplessness, humans are capable of making great efforts to connect with other human beings.
Humans experience loneliness for the first time during infancy (at the age of 3-8 months) while the process of differentiation form the outside world represented by the mother's breast begins. Because of experiencing frustration resulting from unfulfilled nutritional needs, the baby may painfully experience his/ her own loneliness (Mahler, 19962 cited in: Dorr & Friedenberg, 1993). The beginning of the process of separation-individuation reaches its peak in adolescence, when the subjective enforcement of loneliness seems to be the greatest. The particularly strong deprivation of the need for contact during infancy may result in the creation of analytical depression, endangering both health and life of the baby (Reis & Grenyer, 2002).

Loneliness in pre-school children is difficult to diagnose. In his 3 to 5 years old, a child is not able to identify and define sensed emotional states. Recently, the research has proved that typically developed pre-school children often confuse loneliness with boredom (Kirova 2004). The appearance of loneliness in healthy children does not cause any reasons for worry and consideration as the child is only beginning to learn how to interact socially through a process of socialization. Playing with mates constitutes an attractive alternative to everyday life and boosts the cognitive development.

During the school period, children enter a group of peers, make friends and become more sensitive to rejection which may lead to loneliness. A prolonged instance of being alone has proved to show a positive correlation with a depressive mood and an elevated level of anxiety in adolescence (Fontaine et al.,2009; Qualter et al. ,2010). Adolescence is a period during which the company and acceptance of peers begin to have a significant meaning. In the background of maturing, there is a clearly visible dichotomy between the need for community, contacts with peers, and the need for seclusion and isolation from the surrounding environment. Lack of acceptance on the part of peers may cause loneliness and inhibit the fulfillment of major social needs (Pretty et al., 1994). A teenager tends to reflect on his/ her place in the world, to experiment on his/ her own body, that is to change the image as well as try the effects of using psychoactive substances and alcohol. Such activities are especially frequent when accompanied by the acceptance of the group. Sexual drive is also awakened and the possible difficulties in finding a partner can result in the feeling of loneliness. Moreover, adolescence is an important phase in a life of a youth both because of crossing the line ending childhood and because of the need to fulfill specific social requirements characteristics for adulthood.

Adult failures in the sphere of social relationships may result in the appearance of different addictions masking loneliness. The focus on productivity and effectiveness in the professional sphere overlaps the social expectance to set up a family, exerting pressure on the young adult who often cannot deal with.

Senility is characterized by the greatest intensity of social loneliness, when the senior person is particularly exposed to the experience of loss of the peers, friends, and neighbours because of death (Weiss, 1995). Loneliness may become a real threat for the life of the elderly, who not only is not able to deal with the daily activities as their health starts to decline, but also has difficulties in communicating their needs. The creation of a social network of support seems to be necessary in order to reduce the distance resulting in senility.

2.4 Autism and loneliness

Loneliness among autistic patients, suffering from neurodevelopmental deficiencies, is tightly connected with their inclination for isolating from the environment as the consequence of a lesser degree of understanding of the social life. As research has proved, when compared with healthy individuals , the intensity of loneliness is elevated in autistics (Bauminger et al., 2004, Bauminger et al., 2003, Bauminger & Kasari ,2000). The results of an examination of a group of 22 autistics aged from 8 to 14 indicated that an elevated degree of loneliness (measured with the Loneliness Rating Scale) co-occurred with a poorer quality of created friendships when the following ratios were considered: companionship, security and help (Bauminger & Kasari, 2000). Importantly, the ASD children did not indicate the connection of sadness, fear, emptiness or depression with an intensified sensation of loneliness. In these subjects the emotional dimension did not aid the explanation of experiencing loneliness. It was interpreted as a cognitive-social category (Weiss, 1985)

caused by the cognitive evaluation of oneself, and then compared with other children in respect of the quality of created friendships. Nevertheless, having friends did not reduce the sensation of loneliness among autistic children due to the poorer quality of these friendships (Bauminger & Kasari, 2000).

ASD adolescents when contrasted with typically developing teenagers, report an elevated degree of temporal or constant loneliness (Lasgaard et al., 2010) which positions them in a group of chronically lonely subjects (Young, 1978 cited in: Hojat, 1983). It is important to highlight that chronic loneliness in addition to an inefficient social support and a general social dysfunction among teenagers with ASD, may lead to the risk of depression and suicidal moods. Another factor impairing the functioning and deepening loneliness in ASD teenagers is the coexisting anxiety disorder (White et al., 2009). This disorder contributes to the social withdrawal of individuals with autism manifested by unsatisfactory functioning in a group of peers. Researchers draw attention to the fact that the psychopathological picture of both depression and the anxiety disorder in autistics, may considerably differ from the typical picture. When fear is experienced it may include such symptoms as for example repetitive behaviors (White et al., 2009).

High-functioning autistic adults report a pervasive sensation of loneliness in reference to their own dissimilarity and lack of belonging to the surrounding world (Davidson, 2007; Jones et al., 2001). This feeling may be compared to cultural loneliness (McGraw, 1995). Seemingly, the incapability to communicate with others with the use of a language is also a type of loneliness.

As it was reported in the case of depression and anxiety disorders, the picture of loneliness in individuals with autism may differ considerably from the picture in non-autistics. Indisputably, loneliness among autistic patients manifests itself by an intensification of autistic symptoms such as repetitive behaviors, or self- destructive behaviors (e.g. self harm). Episodes of tantrums understood as attempts to communicate with family, can be particularly difficult for the parents of autistics. In adolescence and adulthood loneliness is disguised by different addictions (addiction to computer games, excessive internet use, alcohol abuse). A dedication to one's hobby or work may function as a substitute to inner loneliness in autistics. An additional phenomenon closely linked with loneliness is silence.

3. Phenomenon of silence

Qui nescit tacere, nescit et loqui is an ancient proverb meaning that if someone cannot be silent he cannot speak either and highlights the existence of the phenomenon of silence in the consciousness of the great minds of the ancient times, who indicated its salience as a means of social effects. Not surprisingly, great attention is paid to silence in communication. Linguists distinguish different types of silence in verbal communication (common silence, lack of response, and pause) highlighting its links with language, speech, culture and indicating its presence in philosophy, literature and theory of literature, rhetoric and stylistics (Śniatkowski, 2002). All these phenomena (silence, lack of response and pause) are instances of language use. The main feature aiding the distinction of silence from the other phenomena is the lack of any sounds. Lack of response and the pause are instances of silencer in reference to particular matters, and speaking is acknowledging something else (Rokoszowa, 1994). Silence in its broad context is defined as lack of speech, lack of verbalization, and triggers the non-verbal communication (Śniatkowski, 2002).

From the philosophical perspective represented by Wittgeinstein there is an equation between silence and the inexpressible, stressing the lack of verbal competence to describe a

given experience. The following division of silence into three subcategories is close to Wittgeinstein's approach. 1. Referring to the unuttered/ unvoiced – in the sense of sound production and its lack. 2. Referring to the unexpressed - in the sense of reference to reality. 3. Referring to the unspoken /undeclared - in the sense of conscious strategic decisions (Rokoszowa, 1994, p.36). The phenomenon of silence is also exploited during therapy, and its acknowledgement indicates a shift in the therapeutic process.

3.1 Definition

The formulation of one coherent definition of the phenomenon of silence seems to be a complex task since different researchers tend to underline different features depending on the field of their primary interest.

Thus, the selection of definitions referring to the notion relating to autism appears the most adequate.

Paul Watzlawick, a famous researcher of human communication in the beginning of the 70s, noticed that in a social interaction it is impossible not to communicate, consequently, even silence provides certain information. This observation was particularly important in the context of miscommunication understood in terms of lack of significance for the typical verbal means. Silence provided evidence for dysfunctional interpersonal relationships (Watzlawick, 1972 cited in: Rokoszowa, 1994).

Linguists argue that *silence is understood as such a communicative behaviour that makes the alternative or the frames of verbal utterances. The meaning silence (unlike the transcendent silence) can also be called 'silent language behaviour*'. Whereas a pause is *a formally and functionally differentiated real or potential break/gap within verbal utterances* (Śniatkowski, 2002, p. 97). Silence treated as a framework for language has entered linguistics (Rokoszowa, 1994) and is defined as a necessary background phenomenon of language in its all instances. Since silence constitutes the frame, it may not remain neutral, conversely, it is constant and salient (Rokoszowa, 1994, p.28). The importance of silence as a necessary feature of language functioning has been evaluated, and Rokoszowa (1994, p.29) claims that language in its all functions is shaped and penetrated by silence.

Such picture of silence constitutes the basis for distinguishing the so-called transcendental silence compared to the inexpressible as well as the meaningful silence as a part of verbal communication. Schmitz (cited in: Roszkowa, 1994, p.36) subcategorizes silence into the following types: 1) conspicuous silence – remaining silent when sound/ speech is expected, 2) fitted silence – remaining silent when expected, 3) side-silence – remaining silent when it is not perceived as silence, but remains unnoticed (i.e. pausing in speech).

3.2 Functions of silence

Silence may play various roles depending on the context of appearance. In situations when expected, e.g. in a library, it remains unnoticed constituting the frame for the overlapping activity of acquiring knowledge. In this context, silence, is a factor inevitable for being attentive. In the context of a communication act, silence may disguise both positive and negative emotions.

In the context of some company or public gathering, silence may evoke either a dignified atmosphere, or be a closing element, or the sign of embarrassment. A noticeable silence differentiates itself from other communicative behaviors. It carries meanings which can be interpreted differently depending on the subjective characteristics of the silent person.

Sabbadini describes silence in the following way: *Silence can be a barrier. It can be a shield. It can be a bridge. It can be a way of avoiding saying something and it can be a way of saying what no words could ever tell. It can express anger, excitement, despair, gratitude, emptiness, joy, shame, helplessness or indeed any other emotion* (Sabbadini, 1991, p. 232).

According to Crafoord, silence can take different shapes and he distinguishes: 1).the searching silence (that no words can express), 2).the grey silence (emphasizing the lack of words in a given individual), 3). the passionate silence (carrying strong impulses, inclining towards the danger zone, e.g. sexual desires), 4). the pondering silence (referring to the wordless, mutual conviction about the meaning of the particular kind of silence), 5).the creative silence (which should not be disturbed since it is part of a creative process), 6). the threatening silence (disguising perseverance and obstinacy, protest and separation and being the reaction to anger, outrage, or desire for revenge), 7). the black silence (synonymous with complete rejection and self-destruction, or presence of death) (Ronningstan, 2006, p. 1279).

3.3 Psychotherapy and silence

Psychodynamic psychotherapy may be called "taking cure" since it emphases the impact of words in reference to psychopathological symptoms of personality in patients. From the perspective of psychodynamic psychotherapy silence is interpreted as emptiness and vacuum and rooted in fear of death and annihilation (Lane et al., 2002).

Importantly, silence as experienced in therapeutic environment does not necessarily indicate emptiness, but may be the manifestation to a variety of emotions. It is typically analyzed in terms of preverbal communication and delineates regression in the course of therapy. Silence can be explained as a mechanism aiding the withdrawal to the earlier stages of development. As such it may be interpreted in terms of the desire for control over a object or the desire for fusion with the object in control (Levitt, 2001).

From the traditional perspective, silence equals defensive mechanism of the ego when facing change (Freud 1912 cited in: Lane et al., 2002). It can also be the patient's reaction to wrong therapeutic intervention. According to Sabbadini, silence is a kind of compromise formation, that is the result of a conflict between different mental organizations, or the result of the tensions between different impulses. She claims that most cases of silence in therapy appear in response to experiencing an unconscious fear (Sabbadini, 1991). The basic therapeutic task, in the moments of silence on the part of the patient, is to decide whether or not to break it. And professional experience, sensitivity, tactfulness and the right timing all play a great role in the therapeutic process (Sabbadini, 1991).

Silence from the perspective of the psychodynamic psychotherapy might be analyzed in respect to inner conflicts of a patient, his defense mechanisms and the style of social functioning (Lane et al., 2002). Silence, on the part of the patient, may evoke the feelings of emptiness, helplessness and anger in the therapist caused by the lack of visible progress in the treatment. It is believed that the role of the therapist is to help the patient overcome silence and verbalize his/ her thoughts and fantasies concerning both the current therapeutic situation and the earlier experiences with objects in the life of the patient. The appearance of silence may convey such feelings as anger, fear, sadness, boredom, withdrawal from the contact, or lack of emotions in the patient. It also serves the function of censorship on what may and may not be verbalized (e.g. aggressive or sexual content). When examined from the point of view of the unconscious, it may be associated with the need to return to a safe place, such as the womb of the mother or the cradle or sleep (Lane et

al., 2002). In the conscious surface, the patient may explain his silence in terms of unwillingness to discuss some difficult topics or in reference to difficulty in naming matters adequately (Storr, 1990 cited in: Lane et al., 2002). Nevertheless, it is important to remember that an appearance of silence during the course of the therapeutic process may indicate working through of analyzed experiences and feelings in the patient, providing space for the afterthought concerning his/her behavior. In the final phase of the therapy silence on the part of the patient may indicate a fear of separation and the requirement to begin an autonomic functioning. Additionally, it denotes sadness and pain caused by the necessity of partition from a meaningful object (i.e. the therapist). Silence occurring at the beginning of the treatment may be caused by feelings of transference. Nacht (1964 cited in: Lane et al., 2002) suggests that silence becomes a factor unifying the patient and the therapist (as an ideal object) and the inner integration. Sabbadini indicates that s*ilence is not, or not just, an absence (of words) but an active presence* (Sabbadini, 1991, p.232). She also claims that silence creates space for words which are impossible to express (Sabbadini, 1991).

In silence the therapist may both focus on observing the mental condition of the patient and his behavior and look for an explanation for a particular reaction of the patient to the given words. It is a time for recess contributing to the precise recognition, observation and analysis of countertransference. Importantly, it should be underlined that a prolonged silence on the part of the patient is undesirable because it indicates the retention of the experienced sensations inhibiting the therapist from any therapeutic intervention. It is crucial to recognize the type of silence appearing during the therapeutic session. In the view employing the communicative function of silence supported by Levitt, it is referred to as a pause. He distinguishes a few kinds of pauses: disengaged pauses and interactional pauses. The first one deals with the active avoidance of difficult emotions on the part of the patients, whereas the second type tracks the communicational process in respect to disorientation, the positive self-presentation, the threat to the therapeutic relationships (Levitt 2001). In some cases, silence is a vivid manifestation of an aggressive attitude towards the therapist and if this remains un-interpreted, may hinder therapeutic work in these two personality types (personality of a patient and the therapist) (Sabbadini, 1991). The protective function of silence should not be disregarded. It shields the patient from what he/ she perceives as the destructive influence of the outside environment.

Silence may also become a therapeutic method introduced by therapists in specific situation, e.g. in the phenomenon of holding and containing. The therapist contains the information provided by the patient, transforms it and gives it back in a processed form which becomes bearable for the patient. Furthermore, such remodeled information enables the patients to confront his or her fears and other rejected emotions. The therapist may use silence to frustrate the patient when the need for reflection on inner states is not fulfilled in the words of the analyst. This method may help the patient increase the frustration tolerance level (Lane et al., 2002). Wordlessness on the part of the therapist may both trigger the acceptance of the rejected thoughts, impulses and fantasies, and result in the deprivation of needs, or even in rejection or negation of the therapeutic alliance. Generally speaking, this type of silence creates detachment, endangers the patient's feeling of security and undermines trust, although all three are inevitable during the treatment (Lane et al., 2002). In patients with serious disorders (e.g. psychotics), who do not present a good verbal communication with the therapist, a silent mirroring of the patients' movements is recommended (Blumenson, 1993 cited in: Lane et al. 2002). This method aids the development of the non-verbal

communication and has been practiced with autistics for a long time (Alvarez & Reid, 1991). Silence understood as the countertransference reaction has been interpreted in terms of anger, desire for punishing the patient, or rejecting him, often in return to an improper and nonfunctional response (Lane et al., 2002).

The introduction of silence in the course of the therapeutic treatment must be carefully analyzed and interpreted. Thoughtless therapeutic interventions concerning silence first of all may indicate strong countertransference reactions on the part of the therapist. Secondly, they may threaten further therapeutic cooperation by weakening the therapeutic relation between the patient and the therapist. Should such situation occur, listening to the silence, recognizing its type and identifying of the emotions it disguises along with the presentation of its bearable interpretation to the patient, seem to the best solution. The main issue is to encourage the patient to present his/ her own interpretation of the instances of silences in the course of the therapy. Additionally, the therapist should together with his patient learn how to perceive the silence maturely in social interactions. Silence interpreted in this way would provide the patients with reflecting tool and equip the patient in skills for distancing from others.

3.4 Autism and silence

In the case of autistic patients silence is linked with the lack of or with inadequate verbal competences resulting in disturbances in the exchange of information with the environment. Presumably, language does not serve the autistics as a means of communication, thus in their analysis of the role of silence in reference to verbal communication is out of question. Yet, this assumption does not recognize the strenuous attempts of the high-functioning autistics to communicate with others.

Silence in autism may appear in different degrees. The highest degree of silence is manifested in mutism and is interpreted as complete silence, creating a barrier separating autistics from the competent speech users. The silence surrounding autistics possesses the greatest therapeutic value; it reduces the number of stimuli from the outside environment. In these cases silence serves as a defense mechanism, protecting the unformed intrapsychic space from the chaos, and disarray challenging with the disintegration of the personality.

A case of silence of a lower intensity appears in autistics whose verbal communication is practiced only for self-stimulation and not for interchange with the environment. In these cases pauses are observed and their analysis aids the observation of the behavior of autistics in terms of their needs. Basing on the examination of pauses researchers made an attempt to engage the autistic child in the outside world.

The least intensity of silence is present in high-functioning autistics as well as in Asperger Syndrome patients. In their case silence equals with lack of sound that has its cause, goal and meaning and is suitable for profound psychotherapeutic analysis. The insight into the mechanisms joined with silence in autistics (i.e. social rejection, peer stigmatization, limited interpersonal contacts and loneliness) may aid the formulation of functional ways to deal with other people.

In the course of treatment of autistics psychotherapists often have to bend the fixed analytical rules in order to initiate contact with the autistic child, teenager or adult.

Silence is an inevitable part of the treatment of autistics individuals. Only occasionally does it function as an instance of inner censorship; more often it is connected with the search for temporal harmony, integration and feeling of security especially in HFA and AS patients. Silence not only aids the non-verbal communication with the autistic but also the recognition of the needs, talents and personal interests. While listening to the silence in

autistics, we may discover their personality, pay attention to their emotions, tensions and repetitive behaviors. Silence itself may be analyzed during the therapy, although very few therapists focus on it. Personality features of a therapist play a vital role in examining silence since it can either predispose its retention or interruption. The analyst usually interrupts the period of silence when he senses tensions, fears, lack of tolerance for speechlessness, anger and helplessness. In the case of high-functioning autistics the retention of silence in a therapeutic environment may result in the feeling of rejection, being punished or blamed for prolonging the silence. In the course of psychodynamic group treatment, an autistic individual typically acts as a silent observer, and does not participate in the exchanges between members of the group. Adoption of the role of the observer by autistics commonly results in the feeling of self-inadequacy and discrepancy from the group members. The group may react destructively to the silence of one of its members, fearing negative evaluation and rejection. The increase of frustration within the group as well as the need for cohesion and completeness, may either cause an attack on the silent participant or result in appointing him a scapegoat (Brown, 2008). The task of the therapist is to broaden the scope of tolerance towards instances of discrepancies within the group.

Children, teenagers and adults interpret silence differently. It is most burdensome in the case of the therapy of autistic children, who understand silence in terms of withdrawal and lack of affective relationship with other people. The social communication in autistic children represents a specific problem when the speech disturbances are primal and autistics symptoms are subsequent to them (Rutter, 1988 cited in: Jaklewicz, 1993). A different scenario takes place in the case of patients whose initial decent verbal competencies deteriorate with time weakening their verbal abilities for communicating with the environment. In children who after a period of normal development acquired clinical symptoms of autism still constitute the more promising cases. Nevertheless, in these cases a grueling, long-term, multispecialty assistance of professionals is inevitable in order to rebuild the verbal competences for interaction with the outside world. The clinical picture of autism tends to present a milder case. The interpretation of silence changes in autistic adolescents. The speechlessness of the peers is a more frequently noticeable instance of silence than the recognition of personal withdrawal from speech in company. Autistic adolescents do not sense the discomfort that results from the silence in the context of the peer group. They do not notice that silence may increase tensions, provoke the need for closing the interaction and finally cause the exclusion from the peer group. It is very important during a social training to emphasize the bond between silence and physical and emotional distancing in other people. In HFA and AS patients, in adolescence the need for silence on the one hand and the precise formulation of information on the other, may be interpreted as a particularly economical form of communication with people. This form aims at accumulation of energy necessary for interacting with inanimate objects, ideas and numbers. Silence provides a perfect condition for self-development and learning. In adults silence is perceived mainly in terms of security, though different experiences may change this perception. Consequently, it conveys diverse emotions depending on the context of occurrence.

The link between autism, loneliness and silence is very close. Loneliness can be experienced in silence, and silence may deepen the feeling of loneliness. Both can be accompanied by different emotions (sadness, fear, tension, anger, remorse as well as joy and optimism). Loneliness is sensed not only by the autistic child, teenager or adult but also by their family (Park 1982) struggling to socialize the disabled relative.

4. Conclusion

The aim of the article was to analyze the two factors -loneliness and silence- common both for autistics and people typically developed. Loneliness as an inseparable feature of every human life seems to predominate in the experiences of autistics (Bauminger et al., 2003). The form and the strategies of loneliness as the means for protection against unpleasant emotions are still in question. The tools exploited in the evaluation of the level of loneliness help determine only its two subcategories, namely, emotional and social. The other subcategories of loneliness appearing in autism, that is cultural and loneliness in the interpersonal communication (communicative loneliness) cannot be measured with these tools. The presented characteristics of loneliness and silence aims at a greater understanding of these phenomena as well as a more precise positioning of these features in the clinical treatment of autistics. Significantly, the sensation of loneliness may be inadequately recognized in patients with autism for two reasons. Firstly, the patients with autism have difficulties in identifying and communicating their own emotions and the emotions of others. Secondly, the acknowledgement of loneliness may seem socially stigmatizing in healthy subjects. They may subconsciously generate negative impulses concerning the articulation of loneliness in the disabled. There seems to exist a need for common social dispute regarding the familiarizing of the issue of loneliness on the one hand, and a need for a scientific research of the hypotheses concerning the shape of loneliness in psychotherapy, on the other. Only then the verification of the assumptions may be possible. The number of tools necessary for access to the phenomenon of loneliness is still insufficient. There are no tools enabling the identification of the different shades of loneliness. What is more, autistics and healthy people manifest loneliness in significantly different ways (similarly to the manifestations of anxiety and depression). Loneliness in patients with autism may be disguised by intensified typical pathological symptoms (tantrums, self-injury, self-stimulation, aggression, elevated echolalia). The excessive control of autistics on the part of the caretakers or parents may also result in loneliness. The dichotomy of the needs of the patient and the caretaker may lead to loneliness in both. Moreover, peer rejection separates the autistic from the social environment and threatens with the appearance of additional psychopathological symptoms (i.e. fear, depression – in their clinical picture).The phenomenon of loneliness is often accompanied by silence. Nevertheless, on the contrary to its origin in healthy individuals, in autistics, silence usually designates positive emotions. The reduction of external stimuli may result in both quietening the patient and deepening of the social isolation.

In autistics, the search for the source and meaning of silence seems to be a major issue both during the course of the psychotherapeutic treatment and in aiding the design and selection of adequate therapeutic methods.

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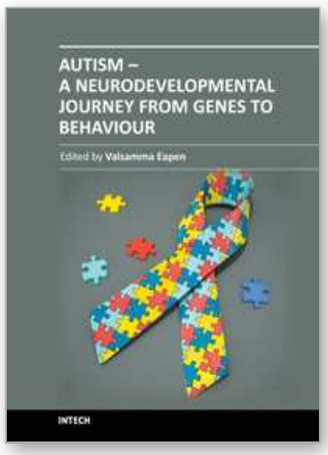
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The book covers some of the key research developments in autism and brings together the current state of evidence on the neurobiologic understanding of this intriguing disorder. The pathogenetic mechanisms are explored by contributors from diverse perspectives including genetics, neuroimaging, neuroanatomy, neurophysiology, neurochemistry, neuroimmunology, neuroendocrinology, functional organization of the brain and clinical applications from the role of diet to vaccines. It is hoped that understanding these interconnected neurobiological systems, the programming of which is genetically modulated during neurodevelopment and mediated through a range of neuropeptides and interacting neurotransmitter systems, would no doubt assist in developing interventions that accommodate the way the brains of individuals with autism function. In keeping with the multimodal and diverse origins of the disorder, a wide range of topics is covered and these include genetic underpinnings and environmental modulation leading to epigenetic changes in the aetiology; neural substrates, potential biomarkers and endophenotypes that underlie clinical characteristics; as well as neurochemical pathways and pathophysiological mechanisms that pave the way for therapeutic interventions.

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