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# Philosophy of Caring in the Psychotherapy with Children and Adolescents Diagnosed with ASD

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## 1. Introduction

This chapter attempts to build a bridge merging theoretical foundations and practical issues with a view to finding a better understanding of helping patients with autistic spectrum. The disorder is not only seen as a severe medical problem, but also as a socially neglected issue. A family with a disabled child or adolescent must cope with different problems depending on physical, psychological or economic conditions to name only a few of them. There must be a complex treatment for the disorder. It consists of many specialist methods, e.g. "holding therapy" techniques based on the TEACCH model, educational and behavioral programs pointed at social skills training or a psychotherapy directed at the psychological problems of a child or his/her parents if necessary.

The psychotherapeutic method employed for autistic children and adolescents may become effective if there is a high level of functioning acquired. Nevertheless, there are some difficulties inherent when including individuals diagnosed with mental retardation into psychotherapy (Berry, 2003). The disorders of autistic spectrum are mostly chronic conditions and therefore require long-term therapeutic treatment. It seems natural that psychodynamic psychotherapy as additional help offered to an autistic person would be considered.

The present content is to recognize potential connections between psychotherapy (mainly focusing on a psychodynamic approach) with individuals of ASD and the basis of the caring concept, primarily attributed to a nursing theory.

On describing and adopting the thesis and philosophy of caring into psychotherapeutic practice on a psychodynamic work with children and adolescents of autistic spectrum the perspective of the relationship available within therapy is expected to be widened.

## 2. Place of care in treatment

Caring is an important factor and should always take place in a curing process. It produces a recovery, leads to well-being or creates the circumstances to exist a sense of safety and then emotional change may be possible.

There are many concepts of it available among various disciplines. Each of them tries to explain why people care for others. Biologists classify caring into instinctive behaviour, sociologists stress social expectations and suggest that caring is simply a consequence of the social process. Anthropologists connect caring with ritual behavior, religion, commitment or power (Wiseman, 1997).

Morse et al. proposed considering caring through five perspectives: caring as a human trait; as a moral imperative; as an effect; as an interpersonal relationship and as a therapeutic intervention (Morse et al., 1990 cited in: McCance et al., 1997). The latter is understood in the terms of a patient's outcomes, but it is hard to use a specific measure to know the care concept better (Sourial, 1997).

## 2.1 Roots of caring

"Care theory" has existed in social scientific discourse with the work of Carol Gilligan, named "In a Different Voice" and published in 1982. Two years later another book was published, "Caring" by Nel Noddings. Both of them were focused on the ethical thinking about giving care to others and put in the feminist context of understanding the phenomenon (Levy, 2006).

Gilligan and Noddings perceived caring as female attribute. Caring is equal to women's work and thus devalued in the patriarchal society. Traditionally, care-giving has been ordered to the ability of building close relationships, usually belonging to a woman's nature. Gilligan pointed out that masculinity is valued through separation, while femininity through attachment, which leads to the conclusion that women judge themselves according to the ability to care (Gilligan, 1982 cited in: Poole & Isaacs, 1997). Noddings has stressed the interpersonal character of care and its role in the ethical response in people. Her ideas were carried over mainly to nursing theory and clinical practice (Dyson, 1997).

### 2.1.1 Philosophy

The philosopher who centralised his theory on the term "care" was Heidegger in a book 'Being and Time' (Heidegger, 1962). He thought of 'care' (Sorge), 'concern' (Besorgen) and 'solitude' (Fursorge), but he did not actually refer the words to ethics (Paley, 2000). The meaning of care based on his philosophy is close to worry about something, which corresponds with the situation of chronic distress, as in families with an autistic child.

There is an important differentiation between caring 'for' others and caring 'about' others. The first implies some action, it is associated with tending to someone's needs. The second is connected with having particular feelings for another person (Graham, 1983; Ungerson, 1983; Blustein, 1991, all cited in: Wiseman, 1997).

Gaut (cited in: McCance et al., 1997) proposed three general meanings of care, which are: attention to or concern for; responsible for or providing for; regard, fondness, or attachment, we can see all of them in the clinical practice on the medical field.

The philosophy of caring is a part of professional ethics, which is the basis for standards for fulfilling its function towards the people requiring the assistance of experts. The requirements of caring are formalized in professional legal regulations, describing the rules of proper fulfillment of its function. Every country has its own regulations in that matter, which should be used in practice and should be treated as a decisive factor in case of dilemmas and doubts.

### 2.1.2 Medicine

There are many models of care in the medical background. Most of them can be found in nursing theory. The first one, which will be mentioned in this chapter, is the theory of trans-cultural caring proposed by Madeleine Leininger: *Caring refers to actions to assist, support, or facilitate another individual or group with evident or anticipated needs to ameliorate or improve*

*human condition or life ways* (Leininger, 1985 cited in: Tuck et. al., 1998, p. 92). To specify her concept of care, Leininger has given 11 assumptions of caring, that are:

1. Human caring is a universal phenomenon, but the expressions, processes and patterns vary among cultures;
2. Every nursing care situation has transcultural caring behaviours, needs and implications;
3. Caring acts and processes are essential for human development, growth and survival;
4. Caring should be considered the essence and unifying intellectual and practice dimension of professional nursing;
5. Caring has biophysical, psychological, cultural, social and environmental dimensions which can be studied and practiced to provide holistic care to people;
6. Transcultural caring behaviours, forms and processes have yet to be verified from diverse cultures, when this body of knowledge is procured, it has the potential to revolutionize present-day nursing practices;
7. To provide therapeutic nursing care, the nurse should have knowledge of caring values, beliefs and practices of the client(s);
8. Caring behaviours and functions vary with the social structure features of any designed culture;
9. The identification of universal and non-universal folk and professional caring behaviours, beliefs and practices will be important to advance the body of nursing knowledge;
10. Differences exist between the essence and essential features of caring and curing behaviours and processes;
11. There can be no curing without caring but there may be caring without curing (Leininger, 1988 cited in: Cohen, 1991, p.901).

The care may be perceived differently according to the culture, where it appears. It may also take different forms, depending on the cultural background.

A second model of caring has been proposed by Jean Watson. She describes human caring and puts it into intersubjective perspective. Caring is presented as sharing one's personal, spiritual, moral and social self (Watson, 1985 cited in: Tuck et. al., 1998, p. 93). Watson (Watson 1978, 1988 cited in: Cohen et. al., 1991, p. 906) mentions 10 'carative factors' which are:

1. The formation of humanistic-altruistic value system;
2. The instillation of faith and hope;
3. The cultivation of sensitivity to self and others;
4. The development of help - trust relations;
5. The expression of positive and negative feelings;
6. The creation of a problem-solving caring process;
7. The promotion of transpersonal teaching/learning;
8. Supportive, protective, and/or corrective mental, physical, societal, and spiritual environments;
9. Assistance with human needs;
10. The allowance for existential- phenomenological- spiritual forces.

In Watson's view of caring, it requires two people (nurse and patient) and leads to the spiritual growth of each of them. The model draws the attention to the problem of perception and adequate response to one's needs.

A third model of caring was proposed by Simone Roach (McCance et. al., 1999 cited in: Ślusarska et. al., 2008), who describes in her "5 C" theory, five qualities of caring:

1. compassion,
2. competence,
3. confidence,
4. conscience and
5. commitment.

Caring is treated as part of being in the world, a basic element of the human condition. In Roach's opinion, compassion is the answer to a special need of the care-receiver. The competence arises from knowledge, common sense, practical abilities, professional experience and the motivation element. Confidence is understood as a basis for caring, it is always present, thus the relationship composed by respect is possible to achieve. The forth quality of caring, which is conscience, connects with a moral judgement and controls human behaviour. The last one, commitment, is regulated by emotional tension between personal desires and duties and the choices between them (Tschudin, 1992 cited in: Dobrowolska, 2006).

### 2.1.3 Psychology

There is an abundance of models associated with “care” in the field of social as well as on developmental and clinical psychology. From the point of view of social psychology, care appears during interpersonal interactions between people and can be analyzed as a social exchange of goods (understood as positive emotions). It involves people who are mutually part of a particular relationship and direct friendly feelings towards the other side of the contact.

Developmental perspective focuses on care as one of the most powerful factors that influence developmental changes, especially of infancy and early childhood.

Erich Fromm treats care as one of the components of love. The other elements constituting love are: respect, responsibility and knowledge (Fromm, 1947).

John Bowlby describes maternal care and its functions in building an attachment (Bowlby, 1969 cited in: Bell & Richard, 2000). He uses the term attachment to emotional bond that child creates with an adult person, his carer, which is mother in mostly cases. The situation implies presence of a dependent and caregiver.

### 2.2 Practical aspects

Care is the basic element in the maternal relationship with a newborn child. Winnicott has stressed that the way a mother holds her child is in essence a transmission of her feelings and it produces a strong bond between them. In the opinion of Winnicott, the three main functions of the mother in relation to her child are: holding, caring and showing objects. These tasks can help to integrate an ego of the child, at first weak and vulnerable to any traumas (Winnicott, 1994).

The dyadic relationship connecting the mother and the newborn child is seen to be a prototype of the caring. The character of the first caring activities responds to the capacity of giving care to others and receiving it from them later in life. It is questionable, whether one can learn and teach others the capacity and whether it is possible to achieve the competence of caring during a psychotherapy process. It seems to correspond with the receptivity of the therapist and the ability to regress on the part of the patient. There is an additional feature of the psychotherapist needed, in the case of the treatment of an autistic person. Patience is the most important and exacting component within this kind of therapy.



### 2.2.1 Care in psychodynamic psychotherapy

The presented description of psychotherapy is mainly based on the psychodynamic approach. Psychotherapy with children and adolescents diagnosed with ASD is generally a difficult task and should be preceded by long-term training, which includes many observations of the normal mother-infant interactions in their natural environment, and theoretical knowledge about human development and its psychopathology. The clinical illustration of early interactions of autistic children must be also present. The supervision and experience of a working team consisting of a variety of specialists would be an imperative element when preparing to work with ASD conditions. The psychotherapist must be trained to listen to and try to understand the meaning of the patient's communication. Beyond the formal demands, he ought to find and practise, within himself, a natural ability to take care of his patients.

An autistic spectrum disorder is seen as a defense mechanism used by individuals, who are too sensitive to defend themselves against the deficit or excess of traumatizing stimuli (Bettelheim, 1972). Another therapist, Tinbergen, noticed that autism may be a reaction of the individual, who experiences strong anxiety in opposition to surrounding external world (Tinbergen, 1986).

Direct observation of autistic children may result in a conclusion that they do not wish for an excessive intrusion into their lives from other people, and a best carer for them would be a carer who does not care. This, however, does not seem true, when we take into account their behavior while playing with dolls, when they copy their mothers' gestures and behaviour. It can be specifically observed during a first consultation with a specialist. Moreover, the need for proper care can be indicated by the frequent repetition of words used by the carer, especially the words of the mother.

The signs of caring should be included in every phase of the psychotherapy, especially with children and adolescents with autism, because of the high level of loneliness which these young people meet in their lives (Bauminger et al., 2004). The care is to be recognized in its verbal and nonverbal forms. A verbal character of caring is identical with the encouragement to social communication, producing the supporting comments, naming the successes and the positive emotions that the patient shows to the therapist, but also verbalizing difficult or negative attitudes toward psychotherapy and psychotherapist in order to help the child or adolescent to face it and cope with it.

Nonverbal signs of caring are needed in the therapist's behaviour and the emotional and physical environment where the therapy takes place. The attentiveness to stable conditions in the therapy room (an arrangement of the chairs, a configuration of papers on the desk or keeping the toys in the same position in the cardboard box, which belongs to a particularly young patient) should be present. The setting is an extremely important factor in the contact with children with autism.

Children with autism do experience emotions, but they have difficulties in identifying them (Ruberman, 2002). The therapist should clarify the child's and adolescent's emotions and behaviours, by using appropriate interpretations according to the developmental level of the patient. The clarifications refer to emotional states and behaviours by the patient and others to ease the disability of reading the minds of others.

The therapy is supposed to help integrate the child's and adolescent's fragmented experiences with himself and the others. Tustin treated autistic spectrum disorder as a part of a child psychosis, which is responsible for a confusion symptom observed in some autistic cases (Tustin, 1990 cited in: Morra, 2002). The non-autistic part of the personality on

which psychotherapy process would be based must be found (Alvarez & Reid, 1999). Referring to healthy parts of the personality creates the possibility of change in the functioning of a child Ruberman argues that psychotherapeutic treatment of children with pervasive developmental disorders ought to be directed to a younger, rather than older age group (Ruberman, 2002). He states that psychodynamic psychotherapy ought to be modified if it is to reach the developmental needs of the young patient.

The care of the therapist is seen in the attempts made to interest the child and to involve him in a mutually meaningful relationship. Sometimes a therapist has to develop a special language to communicate with his patients. It is most noticeable during the role play, in which the adult is invited to take a part.

There should also be some kind of balance of caring and frustration in the therapeutic encounter. The dominance of care interventions familiarises the child with the therapy and prolongs the autonomy process. On the other hand, too much frustration can only be a destroying force and increase the anxiety of the child. As Greenspan states, one of the main goal of the psychodynamic psychotherapy is to develop a connection between an affect, a language and a cognition of the child or the adolescent (Greenspan, 1997 cited in: Ruberman, 2002).

Wolff has proposed four basic psychotherapeutic tasks in psychotherapeutic work with children:

1. To create a non-critical and secure relationship with the child;
2. To enable the child to express freely his inner thoughts and feelings;
3. To understand and underlying meaning of the child's communications;
4. To reflect this back to him (Wolff, 1992, s. 236).

The creation of secure relationships functions as a basis for the therapy and it is connected with increased caution on providing caring interventions, especially at the beginning of the psychotherapeutic process.

Care may be reflected as a cognition of a particular patient. To be aware of any signal of one's emotions, the therapist should be able to recall his knowledge and experiences as well as being open-minded to a new understanding of therapy dynamics.

The psychotherapy with adolescents can activate strong feelings both, on a patient's and psychotherapist's side. The youngsters experience a general conflict between aggression and closeness (Erikson, 1968). They search for caring and avoid it, as well. The therapist is to confront with the difficult and contradictory needs of an adolescent. An important task for psychotherapy is the providing of help to integrate the spheres where the young patient has problems, as within family relations or peer contact. One of the developmental tasks mentioned by Havighurst indicates a tendency to achieving emotional independence of parents and other adults (Havighurst, 1972 cited in: Gander & Gardiner, 1981). Although the adolescent with autism may not reach this developmental stage in the same time as his peers do, he would be also faced with some kind of a separation-individuation process, in his life. Throughout the process, a care is transferred from the family to the outside world. It is helpful to catch the traits of it and support the youngster to handle different feelings associated with the attempts of reaching an autonomy. The psychotherapeutic work must be always connected with supervision, that helps to obtain a better understanding of symptoms, their role in an actual therapeutic relation and to notice the care signals within a curative process. It serves as to capture the possible lack of energy to care for the patients and prevent a burn-out syndrome.

The role of the care concept according to psychotherapy with children and adolescents with ASD is centered on acting to meet patient's needs. There are two ideas of psychodynamic psychotherapy strongly linked to the care theory. The first one belongs to Winnicott's concept of holding and the second to Bion, the author of the container-contained phenomenon. The holding concept takes place in unspecific and constant relationship between patient and therapist. It is based on the rituals like coming to the therapy room of precise hour, one or several times a week. The repetitiveness is intended to smooth the different kinds of traumas. It also enables the experience of the omnipotence of the child or an adolescent. The therapist acting like a mother (an object) who satisfies patient's primary needs or serves as the safe environment, but he is the representative of the reality too, which is sometimes resisted of patient's unconscious desires. Bion's concept of container is seen as understanding and modifying the patient's communications by the therapist. The mother-child relation is likewise a foundation of these actions. The therapist (like a mother in the first months of infant's life) changes the primitive elements of infant's thinking and participates in creation of the infant's self-image process. The original verbal material is to be transformed in the therapist's mind and then turned back to the patient's in a changed form (Bion, 1994).

The caring is incorporated with every step of the two above mentioned therapeutic experiences. There must be an estimation of the patient's ability to accept and acquire the content of the psychotherapeutic intervention.

### **2.2.2 Care in cognitive-behavioral treatment**

Cognitive-behavioral therapy is reserved for patients with anxiety and depressive problems. It was modified to be suited for children and adolescents diagnosed with ASD and an anxiety or depressive symptoms.

The approach is time-limited and it focuses on the present. The treatment is time-limited, usually lasting from 12 to 16 sessions. There is a rational element strongly stressed in the treatment. The goal of the therapy centres on the behavioral change and reduction of a dysfunctional thinking.

Due to the CBT (Cognitive Behavioral Therapy) approach, the autistic disorder is connected with a triad of impairments: social, behavioral and the failures in communication (Rhode, 2010). The cognitive deficits caused by brain defect play an important role in the method selection. The CBT shows a therapist as an active person, involved in the process of changes in the patient's cognitive and behavioral sphere. The way he acts, supports the child or adolescent with autism is essential to the psychotherapeutic effects.

As a model for the disabled child or adolescent, the directive therapist needs to teach the patient the social meaning of care behaviour. He should be able to show care-giving and care-receiving as a part of social interaction. There ought to be a stress put on the patient's thoughts and attitudes including an ability of self-care. Care towards others would be considered as one of the home tasks.

### **2.2.3 Care in humanistic approach**

Within the humanistic field of psychotherapy Virginia Axline proposed eight principles for non-directive therapists:

1. the rapid creation of a warm and friendly relationship with the child;
2. total acceptance of the child exactly as he is;



3. establishing permissiveness so that the child is free to express his feelings openly in the relationship with the therapist;
4. alertness to the feelings the child expresses and reflecting these back to him so that he gains insight into his behaviour;
5. a deep respect for the child's capacity to solve his own problems if given the opportunity, and leaving him with the responsibility for choices and the initiation of changes;
6. no attempt to direct child's behavior or conversation: where the child leads the therapist follows;
7. no attempt to hurry the treatment along;
8. the setting of limits only to the extent of anchoring the treatment in reality and making the child aware of his responsibility in the relationship (Wolff, 1992, s. 228).

The humanistic point of view treats care in terms of subjective category. Similarly to humanistic understanding, there is an existential meaning of care. In the heideggerian standpoint, care is considered as "being with", "being beside", assist in one's experience of loneliness (Heidegger, 1962).

The humanistic components are present in every therapeutic encounter, but that approach does not exist as a separated method for treating ASD conditions.

#### **2.2.4 Care in family therapy**

The treatment of an autistic child or adolescent should be complex and it ought to take care of his family, too. In the family session, there is a need for a neutral posture by the therapist. There is a general rule, not to use the word "patient" about the particular person. Instead it is the norm to treat the disabled child or adolescent as "indicated patient" and to reserve the term "patient" for the whole of the family. That is why, the care is directed to the family viewed as an integral system, which has its own basic rules, its own borders protecting it from an external world, its specific structure and its communication within.

The therapist has the opportunity to see and analyze the dynamics of the care-giving and care-receiving processes between the family members. There is a chance to observe and discuss the conflicts and methods of solving them. Autistic spectrum disorder is an important component of the family system and it influences the whole of the relationship inside and outside the system.

Similarly to the situation of the family with a chronic disability affecting their child, the family with an autistic child meets the same problems. The sense of guilt occurring on the parental side, may be recognized as an irritation towards the medical staff. Also there is a sense of loss of a "normal" child development and the plans for his or her future. These feelings can block the transferring to the next development level of the family's life cycle.

There may be an overdose of the maternal caring of the disabled child, that makes it impossible to take the next step and it results in the isolation of the child and also the family, which cannot find enough support from the social environment. The disorder of the child may divert attention from the marital problems of parents. If one parent takes care of the autistic child, the rest of the family may distance themselves from the situation and suffer from a lack of attention to their problems. They might also be accused by the disabled member's carer, of a deficit of caring ability and a lack of involvement in looking after the child. The siblings might feel rejected and can demonstrate unaccepted forms of behaviour. Sometimes the siblings are the main cause of the application of a particular family to the therapy or consultation (Furgał, 2010).

The autistic spectrum disorder may activate unresolved problems of the family. That is why the therapist must work on problems connected with the actual situation and past problems influencing the present.

There can be two main phases of therapy with a family raising an autistic child (Furgał, 2010). Crisis is the first one. It starts before the final diagnosis is given. The family tries to cope with a difficult situation, future plans are changed, a new daily schedule is organized. At that phase the family is concerned with establishing a sense and value in living with the disabled member. The main feeling is sadness, but the family tries to cope with the problem and creates a flexible readiness for future challenges. The second step seen in therapy, is the chronic phase, that takes place after the final diagnosis. The whole family strives to adapt to the present situation. Acceptance of the changes in family life is achieved. There are new roles of caring negotiated, but it does not mean that the members do not miss the former state, and preview the identity of the family. As new information about autism is delivered, the members of the family balance their needs in accordance with that of caring for the autistic child. The family strives to live in a normal way in spite of the presence of the autistic spectrum (Furgał, 2010).

An important factor influencing the quality of therapeutic work is the attitude of the family to the specialists. If there is an unsatisfactory experience due to the contact with the medical staff, the family might not cooperate with the therapist well. Sometimes the situation arises, where the therapist is seen as a great caregiver and the family members feel free from the duty of offering additional care to the disabled child.

Burn-out syndrome is the most seen problem of a family with an autistic child. The parent (usually the mother) is exhausted by the caring of her disabled child and she needs some rest. The cooperation between the therapist and other specialists who can help (for instance by providing the addresses of useful institutions) is a very important issue. The main problem present in almost every family with an ASD member is connected with different losses (the loss of freedom, the loss of preview activity, sometimes the loss of the money, the loss of the health etc). The therapist should carefully confront the family with these losses and the feelings associated with them.

There can be unaccepted emotions associated with an autistic child, which produces feelings of shame and the tendency to omit the subject during a therapy discussion. Parents may experience conflicts about their situation, the treatment and methods of education of the autistic child. They may have trouble with expressing their thoughts, the problems connected with revealing their feelings.

The treatment is centered on the stimulation of the development of the family. There should be a therapeutic work on increasing the family's sense of control of the treatment. The empowerment of the family serves as additional care. One of the therapeutic tasks belongs to the concentration of the family activity outside the autistic spectrum theme (Furgał, 2010). The family life should extend to the sphere where the autistic spectrum does not appear. It does not mean that the family is introduced to the resignation of care-giving, but there ought to be a sphere where members can develop their own interests, hobbies or activities, to look after the autistic child with renewed energy. Attention to the strong features of the family during the therapy process is necessary. The family may feel confused or surprised, in the beginning. They are not used to listening or analyzing these types of trials, but it can be a chance to see their situation from another perspective.

### 3. Conclusion

This chapter has presented the concept of caring according to psychotherapy with children and adolescents diagnosed with ASD. Psychotherapy is an additional form of treatment and will never be used as the only way of providing help to the children. It can be implemented especially with children with autism who suffer from co-existing psychological problems, anxiety disorders or depression.

The inspiration for the work was the practical problem of emotional fatigue in professionals because of the ineffectiveness of treatment of the subjects with ASD condition and the need for improvement. As one of the participants in the study of the caregivers living with the autistic child had stated: "Professionals in the medical field lack the patience and understanding of dealing with persons with autism" (Phelps et al., 2009, p. 31). Intellectual consideration of the subject of caring and caring behaviours, including both the children or adolescents with autism and their parents or caregivers, results in paying more attention to the various manifestations of care in the specialists' own actions or conduct. It also allows for distancing oneself from the negative emotions of parents of autistic children referred to specialists and helps to overcome the negative feelings of the specialist, caused by the difficult emotions of the caregivers.

This has been a review of the literature connected with "caring" and an attempt to suit the results to psychotherapeutic background due to the treatment of pervasive developmental disorders. Special attention was dedicated to the psychodynamic approach and its involvement in the understanding of ASD during the therapy process. Children and adolescents treat the therapist like their parent, and have similar expectations concerning the care or the lack of care. The therapist should assess the level of expectations and modify it aiming at strengthening the autonomy of the young patient.

The care is firstly considered to be a part of natural human development seen in the mother-child relationship.

The concept of care was introduced to the scientific field by the nursing practitioners and described from the feminist perspective. The application of the concept to psychotherapy practice is worth considering. As Botticelli states, there is a female-dominated profession of psychotherapy. She notes that the treatment was defined to be a provision of care (Botticelli, 2006). Although the psychodynamic approach was much criticized for its inappropriate etiology of the autism (Bettelheim, 1972), one might find a useful understanding of the disorder and its mechanisms.

There were proposals for a linkage between the psychodynamic and humanistic approaches on the basis of concept of care (Bondi, 2008). This content tries to present the characterization of the role of caring in the treatment of children and adolescent suffering from autistic spectrum disorder.

There were described the philosophical frames and practical aspects of the care dynamics. Different views on the care concept may help to broaden the subtle meaning of the social interactions. Care seems to be an important theme in psychotherapeutic work with autistic subjects and it deserves to be part of future research. It is an important task in therapy to make or improve the ability for self-care in the children and adolescents diagnosed with autism, because of their deficits in social development. The ability can be helpful in surviving in today's world.

The research focusing on the concept of care would enrich the understanding of the needs of the individuals with ASD conditions.

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## **Autism Spectrum Disorders - From Genes to Environment**

Edited by Prof. Tim Williams

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Autism spectrum disorders are a major topic for research. The causes are now thought to be largely genetic although the genes involved are only slowly being traced. The effects of ASD are often devastating and families and schools have to adapt to provide the best for people with ASD to attain their potential. This book describes some of the interventions and modifications that can benefit people with ASD.

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