NASCER E CRESCER
BIRTH AND GROWTH MEDICAL JOURNAL
year 2023, vol 32, n.º 4

Nascer e Crescer - Birth and Growth Medical Journal
2023;32(4):318-322. doi:10.25753/BirthGrowthMJ.v32.i4.27850

CASE REPORTS

Growing through grief.
Bereavement after parental suicide in a child with autism spectrum disorder: A clinical case

Crescer com o luto.
O luto após suicídio parental numa criança com perturbação do espetro do autismo: Caso clínico

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ABSTRACT

The impact of suicide on children remains unclear.

Herein is reported the case of a seven-year-old boy who was referred for consultation for behavioral changes after witnessing his mother's suicide. The main complaints were constant questions about death, emotional lability, and motor agitation. During bereavement-focused psychotherapy, some particularities in social functioning were noted, leading to the diagnosis of autism spectrum disorder (ASD).

The bereavement process following parental suicide is modulated by several factors. Understanding these factors in the context of the particularities of the ASD population has allowed for a better understanding of the individual challenges of children that warrant specific interventions.

Much remains to be understood about suicide imprinting in surviving offspring, particularly in children with ASD for whom the bereavement process may be overlooked.

Keywords: autism spectrum disorder; bereavement; childhood; clinical case; suicide

RESUMO

O suicídio tem um impacto nas crianças com dimensões ainda pouco conhecidas.

É apresentado o caso de um rapaz de sete anos de idade encaminhado para consulta por alterações do comportamento após ter presenciado o suicídio da mãe. As preocupações relacionavam-se com um interesse excessivo acerca da morte associado a períodos de labilidade emocional e agitação motora. Ao longo do acompanhamento psicoterapêutico direcionado ao processo de luto, foram apuradas particularidades do funcionamento social compatíveis com o diagnóstico de perturbação do espetro do autismo (PEA).

O processo de luto após o suicídio parental é modulado por diversos fatores. A compreensão desses fatores à luz das particularidades da população com PEA permitiu uma melhor compreensão dos desafios individuais da criança que justificavam uma intervenção específica.

Ainda há muito por compreender no que se refere ao impacto do suicídio nos filhos sobreviventes, particularmente em crianças com PEA, nas quais o processo de luto pode ser pouco compreendido.

Palavras-chave: caso clínico; infância; luto; perturbação do espetro do autismo; suicídio

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INTRODUCTION

Suicide is a serious and growing problem that profoundly affects the surviving family unit and the sociocultural environment of survivors, with repercussions across many generations.[1] Given the challenge that its often unexpected and violent nature poses for survivors, it's impact on children and adolescents is still poorly understood, despite growing interest in early identification and intervention at the level of adverse childhood experiences (ACEs).[1-3]

Because of these unique characteristics associated with suicide, grieving mechanisms also differ from those associated with other causes of death. The grieving process after a death by suicide is associated with a slower recovery process (an average of two years after the death) and a subjective experience of social stigma and community isolation by families.[3] Despite some similarities found in bereavement processes in death by suicide and other causes of deaths, feelings of shame (associated with feelings of dishonor or disgrace and self-failure), rejection, guilt (described as a sense of self-reproach from believing one has done something wrong), and abandonment, as well as a greater need to search for meaning, are exacerbated in grief following death by suicide and may ultimately lead to psychological maladjustment.[2,3] Current literature highlights the increased risk of developing major depression, post-traumatic stress disorder, and suicidal behavior, as well as a prolonged form of grief called complicated grief, which may require unique supportive measures and targeted treatment to cope with the loss.[4]

Children with autism spectrum disorder (ASD) may appear unpredictable and respond to bereavement in ways that are difficult for others to understand. Although the usual principles of grief and bereavement usually found in neurotypical children can be applied to the ASD population, understanding the grief process in these children can only be achieved by taking into account the way they experience the world and their underlying cognitive differences.[5]

In this study, the authors aimed to provide a literature review of the grief process following suicide in the pediatric ASD population based on a clinical case.

CLINICAL CASE

A seven-year-old boy was referred to a Child Psychiatry outpatient consultation by the attending family doctor for behavioral changes after witnessing his mother's suicide five months earlier.

He was accompanied to the consultation by his father, who described a change in the child's usual functioning since the mother's death. The main concerns identified were poor concentration (especially in schoolwork), motor agitation (described as a constant need to move), marked emotional lability associated with maternal memories, and an increased interest in death-related topics, all of which were not present before the mother's death. In the two weeks prior to consultation, the father noticed the disappearance of the previous complaints and a return to the pre-morbid register.

Although unrelated to the mother's suicide, the father also expressed concern about the son's interest in activities normally associated with the opposite sex (painting nails, wearing female clothing, playing with dolls, taking on a female role). Despite adopting a permissive and tolerant attitude toward the matter, he remained very concerned about the emotional and social implications and possible impact on the boy's relationship with his peers.

No significant complications were reported in early development or during pregnancy and childbirth. Early care was provided by the mother with little paternal support due to the father's heavy workload.

Regarding family history, the father highlighted maternal postpartum depression with the need for psychiatric care. The family environment was described as loving and harmonious, and the marital relationship as balanced and affective with complementary roles. Nevertheless, the father admitted a lack of support in parenting, with obvious guilt and self-blame throughout the follow-up.

Several game sessions were conducted over a period of four months, aimed at clinical evaluation of pathological and adaptive processes, during which the boy maintained a friendly and cooperative attitude. He participated in the interactive game sessions only when they focused on topics of his own interest - births and babies. During the first sessions, he assumed a female identity in the game ("Emília"), without any associated anxiety or expressed desire to belong to the opposite sex.

Throughout the clinical assessment, some deficits in social-emotional reciprocity were noted, such as a tendency to polarize conversations around his own personal interests (childbirth and pregnancy), about which he had a deeper knowledge than expected for his age. He also adopted a hyper-familiar profile, sometimes socially inappropriate and bizarre. In moments of excitement, motor stereotypies (flapping) were observed.

Despite a clear tendency to avoid feelings of sadness or other "negative" emotions in direct dialogue, the mother's death and past family routines involving the mother were addressed and brought to light in the game narrative, during which the boy spontaneously provided information about the mother and was able to acknowledge emotional states such as sadness and longing that were present for a period of some months after the suicide, after which he quickly returned to his usual functioning.

In order to gain a more complete understanding of the emotional factors of the grief process, it was deemed appropriate to carry out psychotherapy based on play therapy. A total of twelve sessions were conducted, during which the boy actively participated in the game. However, some peculiarities in social interaction were noted. The boy showed a more rigid posture with little reciprocal participation in the game. He sought out and followed only interactions of his own interest, namely childbirth. He was often hyper-familiar in sessions and showed little understanding of social norms.

In addition to the particularities in social interaction, the language

with peculiar prosody had frequent use of neologisms.

The child's gradual return to premorbid functioning suggested that a nonpathological grieving process was underway. After evaluation, the deficits in social interaction and restricted interests, along with motor stereotypies, warranted the clinical diagnosis of autism spectrum disorder, which was disclosed to the father.

DISCUSSION

Given the particularities of suicide bereavement, one might wonder whether the difficulties observed during the suicide bereavement process are merely a psychological and social response to the nature of death, or whether a larger set of personal, familial, and social vulnerability factors identified in families of suicide survivors might explain children's adjustment to parental bereavement by suicide.[2,3] In fact, a variety of factors influence how children and adolescents respond to the death of a parent, including their age and the quality of the relationship with the deceased parent. These factors are conceptualized within three broad domains: child characteristics, family factors, and environmental factors.[5]

Child characteristics

The child's age and developmental stage can profoundly affect his or her ability to adjust to parental loss and suicide.[3,7] Because of an incomplete understanding of death, younger children may believe that they were the cause of death or that the deceased parent did not love them and therefore abandoned them.[3] Although in the present case, at seven years of age, there is no clear consolidation of the concept of death, there were no feelings of abandonment or guilt, which may be partly due to the protective family dynamic and other temperamental factors such as male gender and personal goals for the future.[6] The boy gradually showed an understanding of the irreversibility of his mother's death, which was spontaneously brought up in the clinical setting in dialogue or play. However, the issue of death was always raised without a clear idea of intentionality.

Family factors

The family impact seen in this case, particularly on the father, was found to be common in the literature. Therefore, it is crucial to consider some family characteristics as important modulators of bereavement in children and adolescents.[7] Globally, a dysfunctional and guilt-ridden family grief process may lead to overlooking the impact on the offspring, thus increasing feelings of isolation in the bereaved child.[3,6,8] Although the shame and guilt felt by the father were clearly present throughout the follow-up, he still managed to provide a supportive and functional environment not only for his son but also for his siblings, maintaining family relationships with a positive affective charge. The open dialogue about the emotional impact of the event and the opportunity to share doubts and difficulties may have contributed to a better outcome, as they are associated with a smoother and healthier grief process, fostering a global integration of the experiences and meanings attributed to the loss.[7]

The child's internal representation of the deceased parent is crucial to understanding the death and maintaining a sense of continuity, and is largely dependent on the memories and information shared by the rest of the family. It became clear that this child maintained a positive and affectionate maternal representation provided by his father and sisters.[6,8] Although the construction of a coherent life narrative may be facilitated if the child is informed of the suicide, full disclosure of the circumstances surrounding the suicide was not appropriate given the child's young age at the time of death.

Environmental factors

Another protective factor found in the literature relates to the quality of community support available to families. In this particular case, the school acted as an important support in which the child felt, sense of coherence in his daily routines and security.[8-10]

Although described in separate sections for ease of understanding, there will inevitably be an interaction between intrapersonal, familial, social, and community factors in influencing the development of protective coping skills in bereaved children.

Bereavement in autism spectrum disorders

As previously noted, the social and behavioral characteristics of this particular child and his developmental history warranted a diagnosis of ASD, which has raised some doubts about the specificity of the grief process in this population.[11] ASD is characterized by qualitative differences and impairments in reciprocal social interaction and social communication, combined with restricted interests and rigid and repetitive behaviors. Some areas commonly affected in these children related to social functioning may affect the bereavement process.[5]

Mind-blindness, a core feature of ASD, refers to the difficulty in recognizing other people's mental states and in responding to them emotionally in an appropriate way.[11,12] This difficulty in empathy, as seen in the boy's constant questioning about his mother's death, can have negative and painful effects on others, as it did on the rest of this family, who were not attuned to him and remained unaware of the impact of his own behavior on others. Another basilar deficit can be found in central coherence, which refers to the difficulty in assimilating and integrating information from our sensory experiences in order to make sense of what is happening around us in the social world and to form a coherent understanding of the whole.[13] In this particular case, we could assume that the difficulty of assimilating as a compilation of information could pose additional challenges in understanding the death process as a hole, including the intentionality of the suicide and the emotional suffering underlying it. Nevertheless, the young age may have a confounding effect that cannot be

overlooked.

Communication is also often affected, with difficulties ranging from a complete lack of functional verbalization to very subtle difficulties in the social use of language, such as deciphering the meaning of nonverbal communication.[4,5] The more concrete functioning found in children with ASD imposes a lack of understanding of the metaphoric language often used by adults when talking about death, increasing misunderstandings and doubts about the topic. This reinforces the need to use language that is not only age appropriate, but also sensitive to the idiosyncrasies of children with ASD.[12]

A core feature of ASD is narrow and intense interests and preoccupations. In this case, it became clear that the child had a limited interest in the birth process, which led to extensive research and constant questioning about the subject. These preoccupations often have a role in reducing anxiety, as evidenced by the sudden preoccupation and insistence on death in this case. This preoccupation and need for reassurance should therefore be understood as the development of effective reassurance strategies in the face of an extremely painful and stressful situation.[11,13] Finally, sensory processing deficits in children with ASD may not only be associated with excitement and positive stimuli, but may also be exacerbated in stressful situations. For example, the "motor agitation" and need for movement described by M's teacher was interpreted as a vestibular search for self-regulatory goals, which was misinterpreted by the teacher as difficulty concentrating and hyperactivity.[14] This is particularly important as it may go unnoticed by untrained professionals and delay clinical referral.[12,14]

CONCLUSION

Much remains to be understood about the imprinting of suicide in child and adolescent survivors, as it is highly dependent on age and developmental factors, and younger children may not have the capacity to cognitively process the concept of suicide and death in general. Children with ASD may have specific problems conceptualizing death and the rituals surrounding it, but like their neurotypical peers, they need their grief to be acknowledged and understood, and they need opportunities to express their feelings.

AUTHORSHIP

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Received for publication: 09.08.2022
Accepted in revised form: 09.11.2022