

Mourning and Reidealization in the Childhood Clinic: Case Study

Luto e Reidealização na Clínica da Infância: Estudo de um Caso

Luto y Reidealización en la Clínica de la Infancia: Estudio de un Caso

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Abstract

Objectives: to analyze the process of reidealization of the child with autistic disorder in the singular clinic of the child and his family; to observe the effects of this clinic on children's linguistic, cognitive and psychic development. **Method:** Clinical case analysis of a two year and eleven month old child diagnosed with autistic disorder, and his mother. The psychological evaluation was performed through APEGI and CARS before and after the intervention, as well as language evaluation through the Signs of Acquisition of Language and clinical observation. **Results:** The process of re-signification of the child's disability through the dimensions of competence, aesthetic and future, was based on the development of the child's linguistic, cognitive and subjective potentialities. **Conclusion:** the reidealization of the child with autistic disorder occurred from listening to the mother and from her discovery of the child's linguistic, cognitive and subjective potentialities, which had a positive repercussion on the child's development

Keywords: Child Development; Family Relations; Early Intervention.

Resumo

Objetivos: analisar o processo de reidealização do filho com autismo na clínica singular da criança e sua família; observar os efeitos dessa clínica no desenvolvimento linguístico, cognitivo e psíquico infantil. **Método:** análise de caso clínico de criança de dois anos e onze meses com diagnóstico de autismo e de sua mãe. Realizou-se a avaliação psicológica através da APEGI e CARS antes e depois da intervenção,

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TDS and DRS – Study conception. ADL and APRS- Orientation.

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assim como avaliação de linguagem por meio dos Sinais Enunciativos de Aquisição da Linguagem e da observação clínica. **Resultados:** ficou evidente o processo de ressignificação da deficiência do filho por intermédio das dimensões de competência, estética e futuro, baseadas no desenvolvimento das potencialidades linguística, cognitiva e subjetiva do filho. **Conclusão:** a reidealização do filho com autismo ocorreu a partir da escuta da mãe e da descoberta das potencialidades linguística, cognitiva e subjetiva dele, o que repercutiu positivamente no desenvolvimento do menino.

Palavras-chave: Desenvolvimento infantil; Relações familiares; Intervenção precoce.

Resumen

Objetivos: analizar el proceso de reidealización del hijo con trastorno autístico en la clínica singular del bebé y su familia; observar los efectos de esta clínica en el desarrollo lingüístico, cognitivo y psíquico infantil. **Método:** Análisis de caso clínico de niño de dos años y once meses con diagnóstico de trastorno autístico, y su madre. Se realizó la evaluación psicológica a través de la APEGI y CARS antes y después de la intervención, así como evaluación de lenguaje por medio de los Signos Enunciativos de Adquisición del Lenguaje y de la observación clínica. **Resultados:** Se evidenció el proceso de resignificación de la discapacidad del hijo a través de las dimensiones de competencia, estética y futuro, basada en el desarrollo de las potencialidades lingüística, cognitiva y subjetiva del hijo. **Conclusión:** la reidealización del hijo con trastorno autístico ocurrió a partir de la escucha de la madre y del descubrimiento de ella de las potencialidades lingüísticas, cognitivas y subjetivas del hijo, lo que repercutió positivamente en el desarrollo del niño.

Palabras claves: Desarrollo infantil; Relaciones Familiares; Intervención Precoz.

Introduction

It is known that the intervention in time, mentioned in the studies of Franco¹⁻³, aims to prevent the installation of psychopathologies in situations of genetic or perinatal alteration, such as in the syndromes and encephalopathy, or in situations in which the psychic constitution suffers, for biological tendency of the baby, for autism or for bonding difficulties⁴. The perspective of these authors differs from the biomedical bias, which focus is exclusive on brain plasticity, many times called, in Brazilian reality, of early stimulation, because, besides thinking about the epigenetic effects possible by plasticity, seeks to offer a unique reading of the needs of each child and his/her family. This is because the development of family and child are mutually related⁵.

When something does not go well in child development, and if there is a relationship with some genetic predisposition, as in autism, according to Franco¹⁻³, there is a need for a process of mourning and reidealization. In this way, the family will have to deal with the mourning of the idealized child in order to relate to the real child, which was born with the deficiency or with the biological limitation.

In light of concretization of diagnosis, a crisis happens, in other words, a break in the process of child development, of the family and the relationship between both of them. Nothing will be as before and nothing will be as the family had imagined². Parents will need to rescue the process of their development in the relationship with their disabled child, to be able to fully exercise the parenting affectively. This, however, will only be allowed when there is the process of reidealization of this real child³.

Such a process generates suffering, which leads the family to have behaviors full of sense and meaning in the care of the child. Depressive feelings, uprising, anger, guilt and denial, are intertwined and may be masked in the grieving process, which causes mental pain and emotional suffering².

There are several factors which will influence the preparation of mourning, such as social support, being intra and extra familiar. Internal issues go beyond the characteristics of the parents, of their personalities, of their stories and their experiences⁶.

The diagnosis is communicated, commonly, by doctors, that do not support families and, oftentimes, do not offer explanations about the child's disability. This causes a sense of total

helplessness in families, precisely at this moment of greater vulnerability. The way the diagnosis is given can trigger negative effects on the family's relationship with the child, making the parents relate to the pathology and not to the subject itself. This situation is aggravated if the parents do not have the necessary support to deal with the characteristics of the child and with their own feelings.

The family, more than any technical professional or therapist, is the main promoter of child development. The therapeutic process of the intervention in time values the active participation of the family institution and works in the interaction of this with the child, aiming at a healthy relationship. Improve family functioning, by means of strategies that help parents in the process of reevaluation of the child, will enable them to become emotionally involved with the child and identify their needs and requests, in order to contribute to family development as a whole¹.

The process of reidealization consists of reviewing, in the real son, three dimensions: competence, aesthetics and the future. The dimension of competence allows the parents to see the potential of the child in order to consider the limits imposed by his/her disability; the aesthetic dimension consists in being able to see beauty in that child and to glimpse it as part of the family lineage. Therefore, it is an important dimension in relation to the family bond. The dimension of the future is about being able to think, desire and plan a future considering the possibilities of the child. This helps parents minimize the present suffering^{3,6}.

In order that all these dimensions are contemplated, the intervention team in time needs to support the family and the baby, or small child, from a look at its uniqueness, which allows to discover the potential of the child in order to glimpse a new project, which includes his/her future and, also, its aesthetic dimension.

This article seeks to thematize, from a clinical case, how the clinical team supported the family in the process of reidealization, from a movement based on the three dimensions, approaching the competence dimension from the child's potentialities for language, play and other daily activities, and the interweaving of this dimension with aesthetics and future in the analyzed case. Thus, in this article, we tried to analyze the effects of the intervention in time in the reidealization process of the child with a diagnosis of autism and, still, how this reideal-

ization was reflected in the process of enunciative support, as a linguistic potential, reason why the family sought speech therapy first. Likewise, the family's reactions to the medical diagnosis will be analyzed considering the therapeutic support given to it.

Method

This work is a study of a qualitative clinical case, performed at a clinical school of Speech Therapy in a medium-sized city of Rio Grande do Sul. It is inserted in the research: "Comparative analysis of the development of preterm and full-term infants and their relation with psychic risk: from detection to intervention.", under number of CAEE: 28586914.0.0000.5346.

It is a case study, of subject B, aged two years and eleven months, which has a diagnosis of Autistic Spectrum Disorder, without comorbidities, and who performed therapy at the school-clinic. The mother, usual accompanist of B, was invited to participate in the research and, after receiving clarification on the objectives of this, as well as after authorization of the study, signed the Informed Consent Form.

The subject was referred to the speech-language pathologist because of the language delay complaint, was welcomed and referred to the Interdisciplinary Center for Child Development (NIDI), which covers professionals in speech therapy, occupational therapy, psychology and physiotherapy. As the core is composed of a team, the case was discussed and the specialties that the child needed to have at the beginning of the intervention were defined.

As the team follows an interdisciplinary psychoanalytic line, one of the group's psychologists performed the psychological evaluation of the case before the intervention, so that, from the psychoanalytic look, could ascertain whether it was a case of autism or unresolved child psychosis. This evaluation was carried out through the Psychoanalytic Follow-up of Children in Institutions, Groups and Schools -APEGI, which is a qualitative assessment that detects the presence or absence of risk indicators for evolution toward a psychopathology or delay in child development, through the analysis of four axes: The Play and the Statute of Fantasy, Unconscious Body Image, the Formations of the Law, the Position of the Subject in Language⁷.

Besides this evaluation, and considering the demand of the neuropediatrician of the case for an evaluation with instrument validated statistically in the Brazilian reality, the psychologist who was responsible for the case, applied the Scale CARS-BR (Childhood Autism Rating Scale-BR) which assists in the diagnosis of childhood autism, encompassing domains that are generally affected in this context, indicating the degree of autism that the child has. Its cutoff point is 30 points. Below this value, it is indicative of absence of autism; from 30-36 points, is considered mild autism and, from 37 points, considered grave⁸.

The analysis of Language was carried out through the Signs of Acquisition of Language⁹⁻¹¹ before and after the intervention. Spontaneous language observations were also made. These evaluations were accomplished before, during and at the end of the one-year period and will form part of the case analysis.

In the case of B, the clinical intervention was given by a pair of speech therapists and a psychologist with the presence of the mother in the weekly session, from a time intervention perspective defended by Franco^{1-3,5,6} where the work is with the child and the family, through the sustained dialogue in the free play¹². Thus, therapeutic scenes included the mother, the child and the therapists, together, in trio or momentary pairs. Sometimes, while the child invested more solitarily in a toy, or interacting only with a therapist, the mother could talk to the other therapist.

The analysis of the data was done through the re-reading of the diaries of sessions, in which there were scenes between therapists, child and mother, and moments of dialogue between mother and therapists. The reading and re-reading of these allowed for an analysis of the content in order to identify how the constant dimensions in the process of parental adaptation to the disabled child were addressed: the dimension of competences, the aesthetic dimension and the future dimension, as well as in what way it allowed to reidealize the child.

In the examples of the scenes that will be quoted below, the therapist 1 corresponds to the speech therapist, and the therapist 2, to the psychologist.

Case presentation

Case B: a boy aged two years and eleven months, who lives with his mother and maternal grandfather and has no contact with his father. His

mother sought speech and hearing care, because the boy was late in acquiring the language. In the host of service, the mother said that B was in the process of diagnosis with a neuropediatrician, since he had signs of autism, which was also observed by the team that sent him for psychological evaluation.

Evaluations before intervention

In the initial interviews, the mother reported that she had no interurrences during pregnancy, but said that B took time to have cephalic control, to sit and to walk. Besides that, he had little eye contact, did not speak and did not show his wills, he had unusual fear of a real plane or even of the toy that represented it. She reported, even, that she suspected a possible deafness, because the boy was slow to answer when called, which was discarded after audiological exams. After a few days, the mother reported that the neuropediatricist confirmed the diagnosis of autism and medicated the boy with Risperidone. However, the mother wanted a second opinion on the diagnosis and did not believe the medication was necessary.

In the psychological evaluation of the boy, the psychologist applied the CARS and B obtained 37 points, indicative of grave autism. In the evaluation APEGI, it was tried to evaluate from its axes, as follows:

Play and Fantasy Statute: he showed no plot, lack of initiative, mechanical manipulation of toys, inconstancy, symbolic poverty, lack of interest in pretend play and repetitive activity;

In the Unconscious Body Image axis: he presented adequate eating habits, accepting to eat, even, vegetables and veggies. According to the mother, B had self-harm, banging his head when he was angry. The child also showed motor difficulties and difficulty to maintain the gaze with the other;

In the Formations of the Law: for him, there was confusion and anguish in the face of the law, no matter how much the proposed limit was explained, he did not seem to understand. Likewise, had difficulty interacting with more than one person at a time, achieving only dual interactions;

The Position of the Subject in the language: B did not speak, only pronounced syllables in an attempt to imitate what was said to him. Sometimes, it was necessary the mother to translate what the boy wanted to express.

During the evaluation process the mother was distressed, with many doubts about the diagnosis,

which were not clarified by the neuropediatrician. She reported that she could not tell whether certain behaviors of him were symptoms of autism risk or whether they were common to every child.

Some questions from the mother were clarified. It was explained to her that autism still does not have a definite cause, but the mother seemed to try to find a specific cause for her child to be at risk for autism, asking whether the diagnosis of B could be due to the father's use of drugs. It was common, in the initial therapeutic process, be given, several times, explanations on the same issue, since the mother was in a period in which she was gripped with conflicting feelings between the ideal child and the real child.

When the mother was asked about her vision of her son, she presented, in her speech, only his limitations, verbalizing: "he does not ask what he

wants; He does not want to walk; he does not speak; he does not play". This suggests that she was overwhelmed by different feelings as a result of the discovery of psychopathology and needed to deal with this situation, which caused him suffering.

After the psychological evaluation and discussion of the case in the team, it was defined that the boy would have psychological and phonological care concomitantly according to the initial maternal demand, referring to diagnosis and language delay. This has been maintained so far.

In the speech-language evaluation, the enunciative signs of language acquisition were used, referring to the second year of life, in view of the fact that B still does not speak. The results are presented in Chart 1 and demonstrate the evolution of B before and after the intervention.

Chart 1. Enunciative signs of acquisition of the language on the first year (CRESTANI, 2016).

SEAL 2 to 6 months and 29 days	First Evaluation
1. The child reacts to the motherese by means of vocalizations, body movements or look.	NO
2. The child fills his place in the interlocution with verbal sounds such as vowels and / or consonants.	NO
3. The child fills his place in the interlocution with nonverbal sounds in a way tuned to the enunciative context (smile, cry, cough, grumbling).	NO
4. The child fills his place in the dialogue quietly only with bodily movements and looks attuned to the enunciative context.	YES, with low frequency
5. The child initiates the conversation or protoconversation.	NO
6. The child and mother (or their substitute) exchange looks during the interaction.	NO
7. The mother (or her surrogate) assigns meaning to the verbal and non-verbal manifestations of the baby, and supports this proto-conversation or conversation when the baby initiates it.	NO (sporadically)
8. The mother (or her surrogate) uses the motherese talking to the child in a tuned way to what is happening in the context and awaiting the baby's responses.	YES
Items 7 to 12 months and 29 days	
9. The child fills his place in the interlocution (utterance) with verbal sounds (syllables with vowels and varied consonants - at least two points and two articulatory modes of consonants).	YES
10. The child outlines the production of words by mirroring the mother's speech (or substitute).	NO
11. The child outlines the production of protowords spontaneously.	NO
12. When the mother (or substitute) is summoned to enunciate by the child, it reproduces its statement and awaits the response of the child.	YES

From the qualitative point of view, the linguistic expression of B, according to the mother, consisted of only a few words / vocalizations in isolation, without communicative function. He had reduced attention to objects, not demonstrating to understand oral language when requested. According to the monitoring of the therapeutic framework, it was possible to understand that B needed to develop, initially, his recognition as a subject, so that he could interact in the plays to access the symbolism and the language, allowed the mother to see the interest and fun of the verbal child. Upon your arrival, B did not present the second and third enunciative mechanisms of language acquisition⁹⁻¹¹.

Clinical Intervention in Double

Initially, the mother did not intervene much during the sessions; she sat far away and only put herself when the boy did not respond to the demands of the therapists. She was extremely attentive to the therapists' actions and her son's responses, seeming to try to figure out how to deal with him. She was enthusiastic when B interacted or could imitate some action during the play.

In one of the sessions, the therapists took a cart that had a telephone. So, they started playing. The therapist 1 picked up the phone and spoke: "Hello B, how are you?", reached the phone for B, and he delivered it back to the therapist. Several times, this scene was repeated. During it, therapist 1 talked on the phone and passed to the therapist 2, which answered: "Hello! I am fine. Do you want to talk to B's mother?" So, the therapist passed it to the mother, and she passed it to B. This movement was repeated several times until B began to imitate, putting the phone on his ear and emitting vocalizations "A...a...a". At this moment, the mother showed great joy and commented "Did you see? He said 'A...'", putting the phone back on B's ear and talking: "That's right B! Hello, speak Hello! This scene was repeated many times.

The evolution of the case occurred from the moment the boy began to establish the knowledge of the language, when he realized that he needed to speak to make him heard, combining sounds and words, still in isolation, establishing, thereby, a co-reference with therapists (2nd enunciative mechanism). The boy began to respond to verbal requests made in therapy session, with repair requests, which were performed by the therapists,

singing music when requested and building symbolic plays. Other examples from the sessions were: imagine that he drank tea without having the liquid or that he could play of making "food" without having something in the "clan". The imitation has been deferred, in other words, today, B can imitate a time after having seen the model given by the therapists, which shows that, from the cognitive point of view, the semiotic function is developed.

In some moments, it was possible to observe that B presented communicative intention, interacted with therapists, included his mother in playing; however, on other occasions, the boy remained listless. The boy's speech was sometimes in a gargantuan way, sometimes so that it became possible to understand what B tried to speak. Still, when the boy wants something, he uses gestures, pointing to the object he wants, not soliciting, nor constructing sentences clearly.

With the progress of therapy, the mother's posture was changing. She participated more actively, as she began to notice how her son was evolving. Therapists provided, during the intervention, moments of pleasant exchanges between the dyad. Also, due to the good therapeutic bond with the dyad, whenever the mother was in doubt or, even, anguished with some fact, she sought the therapists to have the necessary support.

These professionals always respected the boy's desire for the choices of the plays and, accordingly, focused on their potentialities. Concomitantly, explained to the mother that therapy is a gradual process and holding her when the boy, in some moments, was not willing to interact.

The plays that provided pleasant moments, for mother and child, in which she realized that her son had fun and was able to perform, were played at home. Oftentimes, the mother purchased the toys used in the sessions, like soap bubble, ball, modeling clay, chalk, clans. Sometimes, she also built toys. For example, she manufactured a cart track with cardboard once, in one of the sessions, the boy had played and had fun with a clue.

It is important to note that, from the moment that the mother was able to see the potentialities of B, she began to exalt them, both in the dimension of competence, as well as aesthetics. This can be attested in some of her speeches: "therapists, look how beautiful B is! He cut his hair..", "Wow, You have to see how talkative he is!". "I'm thinking of putting him in school, I think he'll like it".

Thus, it was noticed that the mother began to verbalize about what the boy could do, drawing attention to the difficulties and limitations of the child.

In the daily life of the family, one of the obstacles was the social issues of B, since the mother was afraid that the boy had a tantrum moment in places of social sharing and that she could not get around the situation, not being able to also support the gaze of the others directed towards her. For these reasons, whenever the mother left, the grandfather took responsibility for the care of the boy. However, she wanted her son to accompany her. From Therapists' Support, giving space for the mother to express this desire and, at the same time, the anguish in the face of this situation, the mother was able to change her posture and encourage her to take the child with herself when leaving home. In one of the sessions, said that she took the boy to a cafeteria and that he behaved very well and, in function thereof, she was already scheduling to take him to other places.

Evaluations after the intervention

After one year of intervention, the Scale CARS was reapplied by the psychologist, and indicated absence of autism, obtaining 27 points.

On the Play axis and the Fantasy Statute of APEGI, B could already have sequence and constancy in the joke, just did not stay in some activity when that was not his desire. He was taking more initiative, seeking the other to share, not only using the other as an instrument. He also started making exchanges with the three (mother, therapist 1 and therapist 2) at the same time, he bore the other's gaze, and sought the other through his look. He was more curious and attentive, exploring the toys available in the room. Besides that, when he liked something, led to the other to show; sometimes, he called by gestures or pulled his hand to see what he wanted, in other words, he wanted to share the play.

An example of this occurred in a session when therapists sang "the bus wheel turns, turns.." and made circular movements with the arms. This instant, the boy stood in front of the therapists and imitated them, singing "urn, urn", in the same tune, when he had the desire to repeat the music. In that same session, in the part of the song that says "the mother says shh shh shh shh", the boy looked at the mother with the index finger leaning on the mouth making silence signal and emitting

sound "shh shh shh". Faced with this, therapist 2 spoke "Did you see Mom? He's coming to you because the song says that the Mommy does "shh shh shh!", he is asking you to sing". The mother was surprised and happy about it and, so, sang and danced. B asked repeatedly for everyone to sing the song and watched to see if everyone was dancing.

When B was tired, he was quieter and only exploited objects, without interaction and symbolic play, not executing what was requested. Nevertheless, this happened rarely in the last sessions.

In the Unconscious Body Image axis, feed proceeds properly; with regard to self-harm, these happen rarely; the motor slowness, which he presented before, is no longer observed. Thus, he is with motor development suitable for his age. The use of the diaper remains, but started to signal when he expelled his feces, putting his hand on the butt and saying "poop", which demonstrates his body awareness and preparation to perform the removal of the diaper. He makes use of bottle, also using the transition cup; the pacifier, which previously had continuous use, is now only used for sleeping.

In another session, the boy looked at himself in the mirror and his mother spoke: "Who is there B? Who is this boy? Is he the beautiful baby of the mother?" When he listened to this, the boy reacted by pointing at himself and speaking "Yes". At this instant, the mother was excited, smiled and told the therapists "Did you see that he knows!? It's the first time he does this!" As much as it was the first time the boy answered him that way, the mother already assumed a subject and, at the same time, she could see that son as beautiful.

In the Axis the Formations of the Law, still a lot of anguish is noticed when he is contradicted, or it is set some limit. However, the boy's reactions have changed, since now he doesn't throw himself on the ground and he doesn't hit himself anymore, just cries. Thereby, he is better supporting the limits imposed on him.

In the Axis the Position of the subject in the Language, B still has speech difficulties, but has communicative intent and, sometimes, can talk, even if incorrectly, some loose and contextualized words. His mother, sometimes, still has to translate what the boy wants to express, but less frequently. It is important to note that she translates by demonstrating that both have a particular language now, which did not occur at the beginning of the visits.

Slowly, the boy's speech production is approaching what is expected for his age.

The evolution of language, in the speech-language evaluation, was visible, because speech addressed to the allocutionary began to emerge after a year of therapy. Strategies of the second mechanism, as nomination, combination of words and

verbal requests to the allocutionary are present in the language of B, as can be seen in the enunciative signs of the second year of life, shown in Chart 2. These data demonstrate, once again, that language evolution occurs naturally in an approach that prioritizes dialogue in the midst of free play.

Chart 2. SEAL reassessment focusing on the second year of life (FATTORE, 2018)

Signs from 13 to 17 months and 29 days	First Evaluation	Second Assessment
13. The child appoints spontaneously and intelligibly to the adult interlocutor, objects that are absent in the context.	NO	SOMETIMES
14. The child names spontaneously, but not intelligible to the adult interlocutor, objects that are absent in the context, seeking in prosody a way of being understood.	NO	YES
15. The child appoints spontaneously and intelligibly to the adult interlocutor, objects, people, actions, which are present in the enunciative context.	NO	SOMETIMES
16. The child makes gestures to try to make himself understood when the adult interlocutor does not understand him.	YES	YES, the child uses his mother as a translator
17. The child repeats the saying of the adult interlocutor as a way to organize or reorganize his enunciation, for example, improving the syntactic or phonological form or the choice of the lexical item or even accentuating some item prosodically.	NO	NO
18. The child talks to different adult interlocutors (father, mother, examiner).	NO	YES
19. The adult interlocutor gives a possible meaning to the verbal productions of the child, that is, in a tuned way.	YES	YES
Signs 18 to 24 months and 29 days		
20. The child requests objects and / or asks for explanations to the adult interlocutor, marking his position as speaker.	NO	YES
21. The child uses distinct phonemic forms to convey different meanings in his enunciation (at least two articulatory points - labial and alveolar - and two distinct consonant sound classes - at least nasal and plosive).	NO	YES
22. The child uses different forms (words) to convey different meanings in his enunciation.	NO	YES
23. The child combines words, either directly or inversely, to convey different meanings.	NO	YES, a bit of unintelligibility.
24. When the child presents verbal productions distinct from adult speech, the adult interlocutor reacts by asking a request for neutral repair (what) or by correctly repeating the child's speech.	YES	YES

According to the evaluation of language (SEAL), performed in the first year, it was possible to analyze that the boy presented a risk for the acquisition of the language. In the second year (Chart 2) year of the SEAL, it is possible to make a comparative analysis between the first part of the evaluation, which was performed when the boy was 2 years old, and one year after the intervention process.

It is possible to observe that the boy presented evolution in the acquisition of language from the

moment that the therapies had, as objective, the play and, so, make the boy join the symbolism, this being one of the starting points for the development of language skills.

Discussion

In the case of B, it may be noted, in the mother's reaction to the medical diagnosis, something common in the clinic for infants and young children: the mother feels helpless during this

period of vulnerability, in which she begins to experience mourning for the idealized son. Franco³ says that, facing the loss of the idealization of a child, there is the arduous process of mourning, in which depressive feelings are inevitable. This is an immediate reaction to the diagnosis or occurs over time.

When B's mother came to the intervention, her apathy and her difficulty in accepting and dealing with the limits of her son were perceptible. Feelings of stress, anger, of depression or denial are the first emotional responses to the grieving process^{3,13}.

Denial is an inevitable feeling and there can be two dimensions of it: a negative, in which reality is denied, leaving children without assistance, because "supposedly" he/she does not need, or whether to wait to see what happens. And another positive, in which parents are not passive and try to seek second opinions, treatments and more competent professionals⁶.

B's mother's search for a second opinion, about her child's diagnosis, may have been a way of denying the disorder, but, at the same time, occurred in a positive way, because she sought intervention for him, which, by chance, was a timely intervention focused on the family.

The accomplished intervention, in this case, occurred through play, in which it was sought, in addition of promoting language skills, cognitive and subjective of the child, providing a social support to his mother and better family functioning.

Through interventions with the mother-child dyad, providing greater interaction between them and providing moments of listening, so that this mother could explain her questions and be supported by the therapists, it was possible to perceive a change, both in the mother's posture, as well as in her speech. Now, she does not verbalize only the limitations of her child, but his capabilities, even if circumvented by his limitations.

That says of the dimension of competence that Franco⁶ proposes in the reidealization process, in which the family (in this case, the mother) can see and relate to the reality that is imposed on her with regard to the child, at the same time as the competence dimension is already beginning to strengthen. It was perceived, also, that the aesthetic dimensions began when, in the scene already described, in the above case, the mother wants to show the therapists how her son looked cute with cut hair and verbalizes "look how handsome he

looks." In another moment, already cited, this was also noticed when the boy looked in the mirror, and the mother said: "Who is this boy? Is he the beautiful baby of the mother?" These two examples deal with the aesthetic dimension, in which the mother considers her son beautiful and wants to show him to others in the expectation that they also consider him handsome. In the second speech, there is, beyond beauty, the recognition of the child as part of the family lineage.

Complete reidealization is a process that involves the three dimensions, and this happened in the case under study. It was possible to note the establishment of the third dimension, called future, at the moment the mother expressed her desire and began planning to put the child in school and to make new outings with him.

In this case, intervention helped family development, since the process of reuse of the mother and the reduction of the symptoms risk of autism in the child occurred. This fact can be verified when the second application of the CARS resulted in absence of autism, in other words, did not reach the cut-off point. It should be noted that the instrument did not detect the subtler symptoms, but that, even with minimized symptoms, the boy needs to continue with the interventions so that there is continuity in family development.

Final considerations

The intervention in time, when centered on the family, generates benefits beyond the child's development, providing family support so that those involved can overcome the idealized child's grieving process, towards reidealization of the real child. This, as already discussed, covers the three dimensions: competence, aesthetic and future.

Through the intervention performed with the mother-child dyad, in which it was possible to promote pleasant moments for both, focusing on interaction and playing, linguistic potentialities have been developed, cognitive and subjective of the child, managing to minimize the symptoms for the risk of autism.

It was only possible the reidealization of the mother in relation to the real son because the team provided support for her, providing opportunities for listening and letting her express her feelings about the difficulties of having a child with developmental disorder.

In reidealization, the dimensions cover much more than seeing the son as beautiful, capable and with a future. The aesthetic dimension is the one that allows to create affective bonds and that the child is not only restricted to his house. The dimension of competence encompasses the recognition of reality, allows you to see the child's abilities, but also allows his limitations to be recognized. And the dimension of the future is one that understands the desire of what is expected, it helps parents to envision a future for the child and for themselves. This helps them not to be encompassed by the negative feelings that are present in a diagnosis of altering the child's development.

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