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Suspended on a rope: The family unconscious as seen in a consultation with the parents of a preterm neonate

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Summary

The aim of this work is to describe the reflections concerning the psychoanalytic treatment of a couple during the hospitalization of their pre-term newborn girl in the Neonatal Intensive Care Unit. The main activity of such treatment was to recognize and focus the "shared phantasy" and to analyse the couple's co-created relationship. Investigating each partner's family history, the therapist tried to detect the mechanism of repetition compulsion and projective identification. These processes allowed the pre-term birth to be understood as a repeated traumatic occurrence, inscribed in the trans-generational unconscious of each partner's family.

Keywords: couple link, prematurity, shared phantasy, compulsion to repeat, inter-generational transmission.

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Résumé. *Suspendu sur une corde: l'inconscient familial comme il est vu dans une consultation avec les parents d'un enfant prématuré*

Ce projet décrit une consultation avec un couple de parents, dont la fille née grande prématurée était hospitalisée au service des soins intensifs néonatals. L'objectif du projet a été de rechercher le fantasme partagé dans le couple, d'identifier la typologie du lien à la base du couple et de la parentalité. A travers la narration des histoires familiales, nous avons cherché à explorer les mécanismes de compulsión de répétition et d'identification projective, les quelles permettaient de donner du sens à l'accouchement prématuré comme événement traumatique s'inscrivant au niveau transgénérationnel dans l'inconscient familial.

Mots-clés: lien, prématurité, fantasme partagé, compulsión de répétition, transmission transgénérationnel.

Resumen. *En equilibrio sobre la cuerda floja. El inconsciente familiar en una consulta con los padres de un bebe prematuro.*

En este artículo se describe una consulta realizada a una pareja cuya hija, nacida con gran prematuridad, estaba aún ingresada en el servicio de terapia intensiva neonatal. El objetivo del trabajo realizado con los padres ha sido la individualización del fantasma compartido por la pareja, y la individualización del vínculo subyacente tanto en la pareja como padres. Mediante la narración de historias familiares se han ido explorando los mecanismos de coacción a repetir y los de identificación proyectiva. Esto ha permitido la atribución de sentido al nacimiento prematuro como evento traumático que se inscribe a nivel transgeneracional en el inconsciente familiar.

Palabras clave: vinculo, prematuridad, fantasma compartido, coaccion a repetir, transmision transgeneracional

The present clinical case is an example of a brief intervention of a psychoanalytic consultation within an institutional context. The first part of the process is a request for a psychological consultation by the gynaecological ward after a traumatic birth. The second is the elaboration by the parental couple of the traumatic event during the hospitalization of their daughter in the Neonatal Intensive Care Unit (NICU).

The clinical case

I met Mrs. A. for the first time in the hospital's obstetrics department because she requested an interview with a psychologist while hospitalized. Mrs. A. was thirty-five, facing her second pregnancy and carrying with her a 18-month-old boy, who was also born preterm. She appeared

younger than her age, with a small face and a voice of a teenager. Because of a serious disease during her pregnancy, she had given birth to twins at the gestational age of 26 weeks. One died after few days and the other, which weighed about 700 grams, was still struggling to survive in the NICU.
The consultation focused specifically on the issue of how to maintain the relationship with the first child, still too small, during such a traumatic time. Mrs. A. expressed a great anxiety regarding the fact that everything she had built in her life would collapse in the grip of fantasies of death and devastation.
She told me about this second pregnancy. At the beginning, she was expecting to carry only one child until, one day, with the second ultrasound, another amniotic sac appeared, another beating little heart. She had always dreamed of having twins and was so happy in discovering it. She was particularly happy when she found out that this second baby was a girl. She had always desired to name her child after her childhood friend, Elisa, with whom she shared the passion for gymnastics.
Unfortunately, Elisa became ill and prematurely died at the age of 13. When she found out that there were two, she did not know how to name the other baby, so she decided to call Elisa the smallest one, because she was the second to appear and seemed to need a lot of strength to keep going. In a dream in which two little girls were playing together, she "found" the name to give to her second daughter, Aurora.
Unfortunately, Elisa was the one who did not survive after the birth. Mrs. A. was devastated by guilt, and claimed that "For the second time, Elisa has died". She felt guilty because she did not know how to inform her childhood friend's parents to whom she had previously announced her choice to name one of the twins after Elisa.
Mrs. A. had been observing the other baby girl, Aurora, hovering between life and death inside her incubator from which she was not allowed to either touch nor approach. The baby was small, even smaller than the child from the first pregnancy, but not so much. She was afraid that even Aurora would not make it. After consultation, I met her husband and due to the complexity of the situation I suggested the couple to meet once a week during the period of their daughter's hospitalization. They willingly accepted and then started our regular meetings within the Psychological Operative Unit spaces of the Hospital. The hospitalization of Aurora lasted about three months, during which we met eight times. Some meetings were skipped due to the health conditions of their son and some organizational difficulties related to the fact that after a while the husband had to go back to work.

The core theme of this paper is based on the consideration of psychoanalytic couple and family therapy as a tool of analysis and treatment, in relation to birth trauma's.
The initial assumption is that trauma may be the re-actualization of unelaborated past events which may have represented an interruption of the individual or parental psyche's reparative functions.
Since its origins, psychoanalysis has dealt with the trauma of birth (Rank, 1924).
Preterm birth can easily be considered as a trauma enhancer. If birth can be considered a trauma or - using Heidegger's words (1927) - a "being-thrown into the world", this trauma is enhanced by that of the preterm birth, which bewildered parents are compelled to challenge: the unexpected crossroad between life and death concerning their baby.
At the same time, birth can be considered as the moment in which the "infant" is introduced into the family history; he/she takes part in the family's unconscious and is

involved in the complex network of projections and projective identifications of which family relationships consist.

As Nicolò (2015) states: «Parental relations may be co-created by partners in a couple as well as by parents with each child at a pre-symbolic or even pre-reflexive level. Some of these relationships are founded on split-off, sometimes dissociated or rejected aspects, and eventually balanced by their counterparts (partner and/or children). In this sense, family members make up unconscious links to protect themselves from non-elaborated traumas. Such links usually represent the background network on which the family functioning is based» (pp. 74-75).

According to Kaës (1993), the couple as well as the relationship between parent and child is based on links consisting of unconscious alliances: psychological interpersonal structures or functions, or even processes built by the involved subjects and which endorse their psychological life.

"The narcissistic contract", studied by Piera Aulagnier (1975), represents a particular kind of such unconscious alliances. Such a relationship is the fundamental origin of the relationship between the mother and her children, or more generally between the parents and their children. It connects each subject with the surrounding inter-subjective sphere within which children come to their psychic life. The narcissistic contract therefore defines "the sphere where the Ego can take place". Every newborn is part of a group and is assigned a task: to assure and to maintain the existence of his/her group through the upcoming generations in the name of a "narcissistic contract".

A pre-term birth entails both a physical and emotional disconnection: the temporary uncertainties about the prognosis as well as the hospitalization of the baby at the Neonatal Intensive Care Unit make his/her parents suspend any future project on his/her future life. The baby is hardly thought of or imagined by his/her parents. Absence implies a feeling of emptiness and waiting, and upsets the parent's perception of time (Latmiral, 2007).

A pre-term birth easily evokes ancient phantasies of older emotional sufferings (Faimberg, 1987). A feature from earlier times in their parental history can cause the couple to experience incapability and confusion, if the related elaboration has not been achieved (Pezzuto, 2015).

Pre-term family consultations are motivated by the aim of facilitating the relationship of the parents with the neonate, which often cannot satisfy the parental narcissistic expectations, because of the neonate's upsetting "alien" features. Frequently, pre-term children's parents experience higher levels of anxiety, persecutory fantasies and lack of pleasure, due to the prevalence of the reparative imperative to take care of the sick person (Norsa, 2004).

In order to efficiently manage the parental therapy and to understand the multiplicity of psychological phenomena (splitting, projective identification, refusal, persecution and idealization) characterising a pre-term birth, it is of utter importance to remain aware of the way in which a couple co-creates its relationship and how the couple develops a relationship with the neonate and requires it to adhere to the narcissist contract. At the same time, such consultation allows the creation of working areas, where it is possible to

define the couple's family stories, considered as the background sphere in which the traumatic birth experience can be explored and explained.

History of the couple

The couple met through mutual friends when they were teenagers. Mrs A. was trying to overcome the separation from her first boyfriend who was described as "the greatest suffering of her life so far." During the first years of engagement she suffered from panic attacks and vulvodynia, a disorder that made intercourse impossible. Both disorders disappeared after a psychotherapy thanks to which Mrs. A. had mourned the separation, or rather the narcissistic injury linked to the rejection from her previous boyfriend, and the detachment from a very controlling family.
In contrast, her husband came from an unemotional family, and he had found in her "the warmth and attention that he had been missing". After an engagement lasted about nine years they got married, she was 26, her husband a few years older. They did not think of having children right away, they wanted to have fun and travel, things she couldn't have done before because of her father's prohibitions. When they tried to have children, after four years of marriage, they couldn't succeed naturally, and so they proceeded with some medical exams and found out that the cause was a genetic mutation of her husband affecting the conception process.
At the first attempt of Assisted Reproduction Technology (A.R.T.), four healthy embryos were selected, three of these were transferred in the uterus to increase the chances of success. After only a few weeks from the announcement of the pregnancy it was discovered that the embryos of three became five, as a result of cell division.
From that point, a particularly difficult period began in which Mrs. A. had serious health problems due to hyper-hormonal stimulation, which entailed a risk for the health of the embryos and herself. She was several times hospitalized. Four out of the five embryos transferred didn't make it, two were reabsorbed early and the other two remained in the utero but lifeless, inducing a preterm labor at 35 weeks. The only born alive was Federico, who weighed about a kilogram, had severe breathing problems and was hospitalized for nearly two months in the NICU (of another hospital), then once discharged from hospital he managed to recover well.
After about a year from this first dramatic pregnancy and the birth of their first child, Mrs. A. asked her husband to go back and take the last frozen embryo, as she wouldn't be able to bear the idea that an embryo "could remain there by himself". Her husband initially was against this but later accepted and Mrs. A. started a new implantation. After about two months, the first ultrasound revealed that there were two, despite having only one implanted embryo. Mrs. A. reported that she had always wanted to have twins and in her family history twins cases often occurred. The doctors explained due to her "young" age and hormonal stimulation, the chances of a multiple birth were increased. She recalls, however, that from the beginning the doctors cautiously warned her that she probably would have not been able to carry both embryos. On a rational level, she always knew that Elisa was smaller and was not growing. Despite this, the news of her death shocked the mother to the point that she developed an obsessive thought. She would think constantly about her baby that she had never seen and imagined: she would dream of her being older with her other brothers, She would feel that "a piece was missing". She could not bear it, she refused to accept her death despite the fact that the doctors had always informed her of the extreme conditions faced by the embryo.

Since the first meeting we could clearly detect a mechanism of repetition compulsion in the couple and especially in the mother, who, despite the unelaborated feeling of the "loss of her child", underwent an A.R.T. cycle just one year after she experienced a high-risk twin pregnancy.
One more meaningful feature was represented by the "twin obsession": the wish, the preoccupation and the fascination about having many babies at the same time. Two main questions marked the psychoanalytic treatment provided to the couple: what do children represent unconsciously for these parents? How do they consider such multiplicity of babies suspended between life and death? What does this "double" mean at a subjective level and when it is associated to the couple, or to the family?
During our meetings, several aspects arose from the family history of each member of the couple: elucidating the identification with, and the reiteration of the trauma. These features helped me to recognize how such a relationship was built. Detecting the couple's "shared unconscious phantasy", I could identify how they selected each other as partner and constructed their parenthood.

Family histories

Mrs. A. is the last daughter of three children, the first two were boys. She describes her family as close-knit, she received an education that she defines as rigid. Her father was especially anxious and overprotective. He controlled her a lot and she suffered a lot of not being able to go out with her teenager friends. During the first meetings, what impressed me, was the idealized tone with which she would describe the history of her "ideal family" where it seemed that the only shadow was represented by the dramatic current events while everything was calm before.
During our meetings, it had emerged, under the cover of an ideal family, many stories of grief and loss without mourning. His paternal grandmother had six children, one of which died soon after birth, the other were twins and died in a car accident at age of 18, Mrs. A.'s father, the smallest of the six children at that time was only eight years old. Her grandmother, who was very close to Mrs. A., lived at home with her family when she died. At that time Mrs. A. was eight years old and this represented her first great mourning of her life. She described her grandmother as a very anxious and depressed. Moreover, it emerged that even a brother A. (second son) suffered from panic attacks, while the elder one, who was given the same name of his uncle who died at eighteen, had an obsessive disorder, "he was told that his birth saved her paternal grandmother from depression".
It seemed that the common link that connected A. to the paternal family which she felt belonging more (paternal grandmother, father, brothers,) is the anguish for the loss that takes different forms, as anxiety, panic, somatization and obsessive control.
The main theme of the family seemed to be "we need to remain all close because something terrible could happen", the danger outside the family was always present.
Before A. and her husband got married, they decided to buy an apartment in the same building as her parents, even though there was a free apartment that he owned in the house of her husband's family.

Fear of loss, transformed into anguish, panic, somatization and obsessional control, can be considered the link between A. and her father's family (paternal grandmother, father, brothers).
The main theme of this family may be represented by the following statement: "We must be the closest as possible, because something horrible could happen". Danger, outside the family, is felt as always threatening.
Following Melzer's theorization (1983) about family's educational role and his classification of eight emotional functions, we might wonder how such a family manages and shares out its psychic suffering.
A.'s family seems mainly to apply the emotional function concerning the transfer of persecutory anxiety: in this way, the family members will continually feel an imminent danger, as though they should be waiting for an apocalypse.

Her husband G. is the second of two sons, his brother was four years older and lived at home with his parents and did not have an emotional life. The mother after a first pregnancy lost a baby girl, who died after a few days after the birth. He never knew the reason and his mother no longer spoke about it. G. described her mother as a woman shut in her pain, who was unable to convey her affection to her sons, his father worked a lot and was often absent.
G. during a meeting said: "My mother never got over her loss even if she had other children after... maybe there are some griefs, such as the loss of one's child, which cannot be overcome". Hence the fear that the loss of Elisa could also affect his new family and the request for psychological support. As opposed to his wife's family dynamics, her husband family seemed to react in front of the grieving with defenses such as denial, splitting, no emotions can be mentioned, and everything is brought back to a concrete level.

According to Melzer's (1983) we can state that G.' family is self-assured with the emotional function concerning the "limitation of the depressive sorrow". In G.' family, such function usually relevant to parents, is conversely operated by the children and this is representative of families with a non-elaborated mourning. Such kind of condition can lead to emotional spoils and can interfere with the aptitude to convert anguish in the opportunity to learning from experience, turning instead the occurrences into family's disintegration.
A. and G. shared a handy relationship able to grant a flourishing development. They could enjoy a well-established libido and just like a "family-couple" entity, seemed to enforce Melzer's four way of functional introjections (generating love, instilling hope, limiting depressive suffering and elaborating). But when the couple had to face infertility and abortion, A. and G. had to fight against the child's death (shared phantasy) linked with the powerful trans-generational heritage.
«Each member constituting a "family-couple" entity is a unique and irreplaceable element. In this sense, the loss of a child is felt like an intolerable disaster and this can severely weaken the "family-couple" stability» (Meltzer, 1983, p. 61).
When the loss of a child takes place, the intervention of the therapist is greatly significant in order to preserve the family's possibility to continue its development and to avoid the break-up of the relationships.

As for the subconscious of the couple, according to Abraham and Torok's (1987) "crypt theory", we can detect several shades deriving from their past lives: traumatic, excluded, ejected elements that were plainly put out of the psyche or rather "swallowed and kept"
Faimberg (1987) described the theory of the trans-generational psychic transmission. We should then wonder what kind of transmission concerns this couple and, above all, what is the matter of such transmission and how it is transmitted. Faimberg dealt with "inter-generational *teléscopage*" and explained that the transmission concerns identifications with internal objects, parts of them and attributes related to them.
We are now dealing with "alienating identifications": the child is subject to his/her parents' narcissistic founding version of reality, so that he/she has not the opportunity to approach his/her own subjectivity and consciousness.
In Kaës' words (1993), this situation could be defined as a "raw transmission", which is traumatic because not elaborated, aimed at the replication of the same mechanism across generations and therefore not at the symbolization or at a transitional function.
«A transmission can be considered traumatic when the transmitted object shows itself in its dissimilarity and maintains its own extraneousness. Such a transmission has alienating effects and leads the subject to build up transmission phantasms, whose function is to reorganise in a defensive sense the generational positions and to allow a subjective adaptation of the trauma» (Ciccone, 1999, p. 123).
Racamier (1992) defined it as "pathological mourning": rejected mournings across several generations, so that the dead person does not find a place among the ancestors. The dead person remains a "living dead" who survives beside his living relatives, as the evidence of a failed mourning.
According to Racamier (1992), we can consider them as narcissist mournings, never achieved because mostly developing underground: «The exclusion accomplished by the expeller outside his /her own psyche turns into a forced inclusion in the next generation's psyche» (p. 82).

Couple consultation

During the first meetings the main concerns of the couple focused on their first child. After he returned home with his mother, the child slowly recovered, although the anxiety for separation remained and manifested itself through frequent nocturnal awakenings, and the request to sleep with their parents.
Aurora was admitted to the NICU and responded well to treatment, Mrs A. remained very close and after a few weeks the newborn began to breathe better and it was possible to start doing the "kangaroo care" therapy , which involves contact "skin to skin" between the baby and the mother or father for half an hour a day. This was a fundamental moment for the establishment of the relationship with the child during the period of hospitalization. Mrs. A. refers: "It was the first time since she was born that I felt close to my daughter... I could feel that she was relaxing on my chest".
During the long hours of waiting between feeds, mothers are allowed to enter the ward to see the baby (every 3 hours) to put aside the milk pulling it and interact with other parents of hospitalized

children. Soon during a kangaroo care session with "incredible emotion" Aurora started sucking from the breast, and in a few weeks, quickly recovered and gained weight.
Aurora is described by the parents as a very reactive child, even if she has a stiff neck and some difficulty in muscle tone she seems to search actively the interaction. During the meetings with the couple, her husband appeared very confident towards the development of Aurora and never referred to the dead sister, while his wife still focused on the loss of Elisa.

Comments

During the couple consultations, the mother's constant reference to twinship occured, and her inability to engage in the process of mourning of the loss of one of the baby girls, as part of an idealized image of "double". She described being obsessed with twins, seeing them everywhere. These images would reopen her wound, each time. Often, she would also dream of the two baby girls together.
Still being hospitalized, due to medical after-birth complications, Mrs. A. was neither present at Elisa's death nor at her funeral. The difficulty of representing the dead child resulted in a very delicate condition at a psychic level, especially because of the associated mother's omnipotent mandate "to bring back to life her dead friend" since the choice of the name.
However, her husband appeared more focused on the present, "on the living children". He expressed a concrete thought which defensively seemed to be constantly opposed to that of his wife, he feared she may be totally absorbed by depression, feeling he probably had already experimented with her own mother.
We may suggest that the unconscious level of both had been emotionally invested by their respective families of origin, and hence had to identify themselves with a missing part "the son who died prematurely" and "the shadow of a double", from which generated an idealizing and delusional dimension aimed to deny the loss and the mourning. The collusive unconscious pact of the couple seemed to be founded on the magic illusion which denies the missing part, the mourning, through a symbiotic relationship or fusion, in which the birth of a child would repair, in a magical way, the previous losses. The difficulty in procreating represented an intolerable narcissistic injury, which reactivated the ghost of the "lost child".
The use of A.R.T. represented partly, a reparative function and partly a "compulsion to repeat", through the re-actualization of trauma even at the risk of their own lives.
The fact that she had undergone a second cycle of A.R.T. too early, against all medical indication and against her husband's will, witnesses the impossibility for Mrs. A. to create a space of awareness about the desire for a son, as if it was a pursuit for the missing part, the double, on which were split and projected the deadly and destructive dimensions, not "digested".
During Aurora hospitalization months, the counselling for the couple focused on the representation of the vital aspects of their child and supported the parent-child bond. The latter consisted in supporting on the one hand, the primary relationship with practices such as kangaroo care, breastfeeding and recognition of communication signals from

their child, and on the other, through the containment of the destructive aspects related to the anguish of death, which risked affecting the relationship with the children and the couple.
In the "here and now" of the institution, a container of various symbolic meanings such as birth and death, the intervention with the couple represented, then, the opportunity to build and strengthen a psychic shelter. This would be necessary in order to contain the destructiveness of the pain, and create the basis for awareness on the psychic contents related to both, birth and parenting by linking the past losses and the present ones (transgenerational transmission).
In my countertransference, I sometimes felt that the anger expressed by Mrs. B., related to the loss of her sister, was a highly ambivalent feeling.
The narcissist regulator shows an anti-mourning defence working through denial and scission. Mourning is thus trapped within the psyche. Later on, after the phantasm is unfolded, the mourning will be evacuated and carried outside the psyche through an interactive and manipulative behaviour (Racamier, 1992).
Due to the repetition and unwillingness to accept the loss, I felt the sense of guilt, partly linked to the omnipotent challenge of having a child at all costs through technology, and partly linked to the unconscious attempt to project, with the choice of the name "Elisa" to one of the baby girls, the ghost of "the dead" transmitted through trans-generational levels. Hence, this fantasy (fear/desire) to forget Elisa, as if she had to let go her childhood friend and her dead child, meant at the same time, to let go her inner child (double mourning) and access to motherhood as a grown up, and contact the limit.

The dream

G. during this session speaks little, often appears as absent, he looks around, almost seems estranged, especially when A. begins her long monologues in which she cries and repeats exhausted, with a monotonous voice her anguish for the dead child.
Then, he says he had done a dream, it is the first time that it happens during our meetings and decides to tell it, "he was on a beach, maybe there A. was also there but he could not remember it well, it was almost night, after sunset, he walks towards a very dark side of the beach where there is a kind of fence, it is dangerous to get close to it and yet he is driven by curiosity, and together with another person, a person (who he had never had contact with) tries to see what's beyond. Meanwhile, he observes in the sea, suspended on a rope, two children, of 5-6 years or so, able to stand perfectly in balance as acrobats heading to the dark side of the beach, without feeling they were in danger".
Then the therapist suggested to free-associate.
G.: says that the two children could represent as well as their children, him and Mrs. A., and that the dark side represents the pain and the suffering that makes their lives hang in the balance.
A.: is very distressed and seems unable associate. According to her, this dream only seems to confirm the fact that because of themselves their children's lives were hanging in the balance, thus in danger.
T.: I comment that this "suspended" dimension is a characteristic of preterm birth. The sea indicates the children struggle between life and death, the rope may recall the "tubes" attached to

the premature babies to support breathing and feeding. I find very evocative the fence and linked it to the fact that, during her children's pregnancy, A. had to do a "cerclage" because of "the uterus incontinence." But perhaps in addition to their prematurely born children, there are two other children who prematurely felt pain and felt in a state of uncertainty. These children may represent also Mrs. A and G. as two children exposed too early to pain without a safety net that could protect them from feeling a state of uncertainty, because they didn't feel able to contain their fears and those of their children (A. appears very moved, his eyes are filled with tears. G. stares into space).

The couple have proven over time to have a very strong bond, with considerable resources on the libidinal level, which on the parenting level has protected children during a very critical situation.
During the consultation, the firstborn son was able to improve its development with sufficient serenity, peacefully returned to school and went back to sleep in his own room. Her sister, Aurora, despite of her severe prematurity, didn't present any particular difficulties during her development. The consultation meetings with the couple ended with the discharge of the child from the hospital. After a few months Mrs. A. called me and asked for an individual space in which she could try to mourn her child and the inner child part of herself.

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