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WE HAD A DREAM OF A CHILD: THE PSYCHOANALYTIC THERAPY AS A MYTHOPOETIC SETTING FOR COUPLES WITH GENETIC PROBLEMS[18]

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Introduction

Nowadays, with the revolution of the techniques of Prenatal Diagnosis, it became possible for the couples to know about the health condition of their babies, during its gestation. If a couple has, for example, a genetic disease diagnosed in the family, the medical team can offer them the possibility of making a genetic test that will diagnose the fetus. If this disease is severe and if it is confirmed that the fetus has the disease, then the couple can choose to continue or terminate the pregnancy up to a certain gestation period depending of the law of each country.

[18] Communication presented at the IACFP, July 2012, Padova Meeting.

Without going into considerations about genetics, we would like to remind you that there are some hereditary diseases whose risk of being transmitted is extremely high. When the transmission is autosomal dominant, the child's risk of being affected by his/her parent's disease is as high as 50%. This means that a couple who is planning to have children is faced with a game of "heads or tails", each time they try to get pregnant. With this in mind, it is clear that these new techniques pose a challenge to 21st century couples who are at risk of transmitting a genetic disease, as they can make choices about their descendents and future generations.

To understand these couples' (in)decision of having or not a child, we should try to answer the question: what does it mean for the couple and their families, to end or to promote with the transmission of the disease to the next generation?

To reflect on these issues we would like to share with you, throughout the presentation, a clinical case that we have been following in co-therapy at the genetics department.

Clinical case: Ann and Paul, are two 36-year old, anthropologists, married for six years. Ann is one meter and thirty-one centimeters tall dwarf. She is blonde, blue-eyed and very feminine. Paul is a tall man and has almost two meters, with a clumsy body. The couple has a 2-year old son named Matthew. Ann has pseudoachondroplasya which she inherited from her father. He was the first clinical case of dwarfism in the family. The transmission risk of Ann's disease to Mathew is 50% and before becoming pregnant, they were aware of that risk, so the decision of having a child of their own had to be pondered for several years. They also knew that they could make a genetic test that would help them diagnose the fetus. However, the couple decided not to do it. As this disease is not manifested in early childhood, they continued to be in doubt about Mathew's dwarfism. The request for therapy arose when they decided to test Matthew.

The genetic mutation or genetic disease, that unknown thing: in the Self, in the Couple, in the Family

Jon Weil (2), an American psychologist who works with couples and writes about the psychosocial aspects of genetic counseling, reminds us that each element of the couple brings to the relationship: expectations and relational patterns learned in childhood; social, cultural and religious norms; expectations about sexuality, reproduction, social relations and marriage, but also emotional deficits, traumas, and the hope to see them compensated through the couple relationship. In this sense, could it be possible for the adult patient to compensate his deficits and traumas, his limitations and symptoms, through the couple's relationship?

While providing support to the couples of the Genetic department, we have noticed that the couple's link is a good opportunity of repairing the patient's *Self.* As Eiguer advocates, while the couple builds an intersubjective relationship, they get in touch with each other's past and present; they share their each other's wishes and aspirations, and they also get to know their individual needs and difficulties. It's this mutual knowledge that legitimizes the union between different subjects (3). To know the Other, who has a genetic disease, involves knowing his/her illness, his/her physical and psychical conditions. This is seen in Eiguer's (3) principle: the *Mutual Recognizing* of the Other´s psychical state and his/her difference. But as the same time the disease is known by the partner, he/she takes to himself the suffering and fate of the ill spouse. This is seen in the principle of *Responsibility* (3).

We therefore believe that, in constructing an intersubjective link, the patient feels accepted for who he is, building a new identity of "We-couple". In other things, the healthy spouse will also be compensated.

Clinical Case:

We have said earlier that the couple had decided against genetic testing of the fetus. During the sessions, the reasons for such decision popped up. On the one hand, Paul and Ann were defenders of life, so they both were against abortion. On the other hand, in terms of "disability", Paul thought that society was too inflexible. He argued that "normality" was just a concept, a social myth. We believe that Paul's acceptance of the disease as a difference, rather than as a disability, had the purpose of defending Ann, because he knew she had always felt different. In fact, he said that if they were to terminate a pregnancy of a sick child, he would feel as if he was

rejecting Ann. Paul always used the term "condition" to refer to Ann's illness. At the same time, during therapy, we realized that Paul had himself lived excluded from social groups, including from his own family. As a withdrawn child and a reserved teenager, he had lived in an almost "non-existence". When Paul found Ann and her family, he finally belonged to a social group.

Practice has showed us that many genetic patients have always lived with a feeling of "being different", of rejection, and with the sense of "not belonging" to social groups. Patients that have physical disabilities may cause curiosity and strangeness on the Other. If the disease is chronic, then the patient may have experienced a long history of medical appointments and been subjected to repeated invasive and painful procedures.

The disease can also be perceived as threatening because of its unknown evolution, creating over the patient and his family many scaring fantasies. Faced with anxiety toward death, anger for being different, the frailty of the body Self-image, it's not surprising that these patients may have developed narcissistic defenses.

Considering these diseases are hereditary, then the feeling of "not belonging" could have crossed generations. This increased fragility of the family can even be responsible for establishing narcissistic links between its elements, as a form of protection from the community.

Clinical Case:

We haven´t mentioned Ann and Paul's communication yet. Since the first session, we noticed an asymmetry of power. Whenever referring to Ann, Paul use expressions like "my beloved spouse". But Ann was often depicted as threatening, impatient, aggressive, she would stretch her finger, opened her mouth widely, like she was an animal that threatens to devour. When facing Ann's expression, Paul's reaction was often look down. We felt this acting as a sadomasochistic manipulation. Often with the impression we were watching a theater, each of them was acting as if they were playing a role. We understood Ann's behavior as the role of someone who has to devour to protect herself from being devoured. This made us think about Ann's family, of their feeling of being devoured by the social group.

We had a dream of a repairing child

While supporting couples who are in risk of transmitting an inherited disease, we have comprehend how difficult the decision of having a child who could possibly be ill must be. Maybe another way of repairing the patient's narcissism would be to dream, in a shared dream with the partner, of a healthy child. Perhaps this dream could repair the narcissism of the entire sick family. The sick adult might even be dreaming the dream of his/her ancestors when he/she desires a healthy child. In other words, the healthy child can have a repairing function of the family's identity. *My parents had dreamt about a repairing child, but I wasn't able to fulfill it, now I can only dream with a healthy child to repair their narcissism and mine too.*

As mentioned by some authors, as Freud (4) and Kaës (5), even before its conception, a child is placed in a depository position of the parental narcissism, and of their dreams and unfulfilled desires, and this would be no different in this case. This brings us to the narcissistic family contract of Kaës (5).

Clinical Case:

When the couple chose the name for their child, they decided on the name Matthew. Ann and Paul chose "Matthew", from the Hebrew "Mattiyah", which means "a gift from God". Matthew, considered the more intellectual apostle, was knowledgeable on the scriptures and traditions.

We had a dream of a child with a new identity

But what could represent a sick child? Could the hereditary disease represent the continuity of an identity, as a surname that crosses generations? We would like to remind you that, patients who have the same genetic mutation, share certain physical resemblances. Therefore, it wouldn't be surprising that different elements of the family, with the same mutation, would be represented as equals, in other words, with the same identity.

We want to share with you a story that has been told for years at the Genetics department. In Azores archipelago there is a neurological disease, named Machado-Joseph, which is severe, progressive and disabling. This

illness is transmitted from parents to children with a 50% risk. There is a specific island, named Flores, which is particularly small and to which access is quite difficult. This makes marriage amongst its inhabitants a common thing so the transmission of the disease is very high. Despite not having a scientific proof of this, doctors say that the population seems to accept the transmission of this disease peacefully, as if the disease was a normal physical trait. Perhaps this belief in the disease as a standard feature makes it easier to accept it. This belief shared by several generations, would be as a social myth that narrows the inhabitants' links. From this example, we could also think of genetic disease as an *identity marker* in a family. Therefore, with the transmission of the genetic mutation also goes the transmission of an identity, as a *psychological gene* (6).

Besides being an extension of a family, the new generation is the combination of two existing families. In these cases we have a family with the genetic disease (identity marker) and another one without it. How could the healthy family accept that identity marker? When a child is born with the disease, could he/she be perceived has an attack to the healthy family's identity?

Clinical Case:

Ann's Mathew's pregnancy wasn't accepted by Paul's family. The couple imagined that a child would not be well accepted since Paul's parents seemed to avoid talking about grandchildren. The couple had already experienced from his family a "non-acceptance" message of Ann when Paul's mother refused to attend the wedding. On the other side, even though Ann's mother was quite anxious about the possibility of having a dwarf grandson, she made herself available to support her daughter during and after pregnancy. In fact, Ann's mother moved to the couple's house to take care of the baby and it was her providing maternal care to the baby. Today, Matthew uses the word "mother" for both Ann and his grandmother. During the therapeutic work, the couple became aware of the fact that their son is also a gif to Ann's mother, who didn't have a healthy child of her own.

We would like to leave you some final notes on the counter-transference and inter-transference as guidelines for our understanding of the case. As

Eiguer (1) remind us, the analysis of the counter and inter-transfer is as a "cornerstone" in the healing of the family.

Counter-transference

In one session, one of us made the mistake of swapping Paul and Matthew's several times which made Ann extremely angry. During this session, the couple was telling us the following episode.

Clinical Case:

Ann, her mother, Paul and Matthew had gone to the supermarket. At one point, Ann was distracted, and for about a minute Mathew disappeared. Distressed, Ann went from corridor to corridor calling for Matthew, to no reply. When she found Mathew, who was hidden and in silence inside a Play house, she became very angry and even hit and scolded him. Ann shared with us her fear of him having been kidnapped, but also her feeling of powerlessness to move quickly through the supermarket. She imagined that Matthew could certainly run faster than her and that she wasn't able to catch him.

This episode depicts the process of separation - individuation (7) of Matthew. Now that he is 2 years-old, he uses mobility as a way of managing the approach versus separation of the Object. The change of names by the therapist allowed us to suspect that a process of Paul's individuation was also being developed during therapy. This data would be important to think with Ann, her difficult to deal with the individuation of the Other and whenever he reveals to be different from her.

Clinical Case:

In a session we realized that Paul had not enrolled in a Masters that he really wanted to do because Ann, who also wanted to attend it, was pregnant and immobilized at the time. The couple felt that it would not be fair for Ann, if Paul attended the Masters without her.

Inter-transference

At the end of a session, one of us was perplexed by the fact of having spent a lot of time (of the session) admiring the other therapist's boots and even commented on how much she wanted a pair of boots for herself. At the time we laughed, but as we discussed the session amongst us became evident that the feeling of envy from Ann to the therapists reflect a

difference between Ann and Paul's abilities versus inabilities, to walk, for instance. Often, Ann described us her disabilities and got angry with Paul because, in her view, he didn't put to use all the tools he had in order to compensate the couple for her difficulties.

Clinical Case:

Ann told us of her inability to take long walks and said that, Paul was quite fond of them. While caressing Ann's arm, Paul said: "If my beloved spouse can't go, then I have no interest in doing those walks without her ..." Ann replied in an aggressively way, and shouted: "Why don't you understand that there are things that I can't do? If I can't go for walks, then you must go!" To us, this is an ambivalence sentence.

Final Thoughts

Although the couple only requested therapy when they decided positively to the child diagnostic test, both of them recognized that marital conflict had increased ever since the birth of the baby.

The fulfillment of the couple's wish of having descendent clashed with the terrifying possibility of having generated a sick child.

Although the topic of discussion was often the difficulty in sharing household chores (with Ann accusing Paul of irresponsibility) it became clear that the discussion had more to do with the roles they played in the family than anything else. The couple had serious doubts about their individual and parental abilities to help Mathew's inclusion in social groups, if turned out to be a dwarf.

In the beginning of Ann and Paul relationship, in a level of Resemblance (3) they shared a common feeling of "not belonging" to social groups, when they became parents, that resemblance was a disturbing question, since they didn´t know how to compensate their limitations and save their son from them.

At the oniric level of the intersubjective link, as a result of *Echo* (3), the couple expected to accomplish their Self-Ideal desires, their ambitions and projects, dreaming each other dreams: *We had a dream of a child.*

With this presentation we tried to reflect on the contribution of psychoanalytic theory of couple and family to understand the unconscious process of the couples who, in the 21st century, decide to continue or to stop the transmission of the family genetics in future generation.

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