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Crossing the storm together: Supporting couples in the perinatal mourning process in a hospital setting

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Summary

The death of a child is the most traumatic event in family history. Working in a hospital in a Maternal-Child Department, frequently means to be forced to deal with the drama of the death of a child at the perinatal stage, at the womb stage or immediately after birth. These losses have profound effects on couples and are perpetuated at a transgenerational level. Each loss has a specific meaning depending on the couple's evolutionary phase, on the possible presence of other children. It is also related to the meanings attributed to pregnancy in the history of the couple and the family, at an intra-psychic and inter-psychic level. The aim of this work is to describe the support path to the perinatal mourning and its processing through several meetings. It has been carried out with couples in a psychoanalytic setting, within an institution. The aim of such meetings was to help both the partners going through their psychological suffering, to get in touch with their deepest emotions by sharing them in a safe context. Each cycle of meetings lasted one year on average. It has allowed many

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couples to avoid a pathological crystallization over perinatal mourning and to contain the massive manic defenses that could undermine the couple's bond eventually preserving the creative resources of the couples.

Keyword: intrauterine foetal death, mourning, couple psychotherapy, couple link.

Resumen. *Atravesar la tormenta juntos: apoyar a las parejas en el proceso de duelo perinatal en el ámbito hospitalario*

La muerte de un hijo es el evento más traumático en la historia de una familia. Trabajando en un hospital, en un Departamento de Atención Materno Infantil, a menudo nos encontramos con la tragedia de la muerte de un hijo durante el período perinatal, ya sea en el útero o inmediatamente después del nacimiento. Estas pérdidas tienen profundos efectos en las parejas y familias, perpetuándolas a lo largo de las generaciones. Cada pérdida adquiere un significado específico según la situación actual que vive la pareja, la presencia de otros hijos y los significados atribuidos al embarazo en la historia de la pareja y la familia, tanto intrapsíquica como interpsíquicamente. Este artículo describe un proceso de terapia de duelo perinatal, realizado con parejas en un entorno psicoanalítico, dentro de un entorno institucional. El objetivo de estas sesiones es apoyar a las parejas en la gestión del sufrimiento psicológico, conectar con sus emociones más profundas y compartirlas con su pareja en un entorno seguro. La serie de sesiones, que duran una media de un año, ha ayudado a muchas parejas a evitar cristalizar el duelo perinatal como patológico y a contener las defensas maníacas masivas que podrían minar el vínculo de pareja, preservando así los recursos creativos de las parejas jóvenes.

Palabras clave: muerte fetal intrauterina, duelo, psicoterapia de pareja, vínculo de pareja

Résumé. *Traverser la tempête ensemble: soutenir les couples dans le processus de deuil périnatal en milieu hospitalier*

La mort d'un enfant est l'événement le plus traumatisant de l'histoire d'une famille. En milieu hospitalier, au sein d'un service de soins maternels et infantiles, nous sommes souvent confrontés à la tragédie du décès d'un enfant pendant la période périnatale, que ce soit in utero ou immédiatement après la naissance. Ces pertes ont des conséquences profondes sur les couples et les familles, se perpétuant de génération en génération. Chaque perte prend une signification spécifique selon la situation actuelle du couple, la présence d'autres enfants et les significations attribuées à la grossesse dans l'histoire du couple et de la famille, tant sur le plan intrapsychique qu'interpsychique. Cet article décrit un processus d'accompagnement du deuil périnatal, mené auprès de couples en milieu psychanalytique, en milieu institutionnel. L'objectif de ces séances est d'aider les couples à gérer leur détresse psychologique, à se connecter à leurs émotions les plus profondes et à les partager avec leur partenaire dans un environnement sécurisant. La série de séances, qui dure en moyenne un an, a aidé de nombreux couples à éviter de cristalliser le deuil périnatal comme pathologique

et à contenir les défenses maniaques massives qui pourraient miner le lien du couple, préservant ainsi les ressources créatives des jeunes couples.

Mots-clés: mort fœtale intra-utérine, deuil, psychothérapie de couple, lien de couple.

Intrauterine Foetal Death

Compared to the beginning of the last century, perinatal death is now a much less frequent occurrence in Western countries, thanks to the advances in obstetric and neonatal care. Despite this, Intrauterine Foetal Death (IUFD) remains one of the most common adverse outcomes in pregnancy and occurs in approximately 3 out of every 1,000 births in the industrialized West. People are having fewer children and delaying parenthood until an increasingly advanced age. This leads to a consequent increase in risks, particularly those related to the health of the mother and of the newborn. In today's families, children are the culmination of a demanding and often late investment for the parents, sometimes as only children who must receive the best, sometimes idealised and burdened with high expectations. This fuels an idealised, often distorted view of pregnancy and parenthood, to the point of denying the precariousness and fragility inherent in the human condition. The grief, loss and suffering that are part of the evolutionary path of every individual, couple or family are often denied from birth. Yet childbirth is a liminal condition of uncertainty and unpredictability, capable of transforming a joyful moment into tragedy. By its very nature, IUFD therefore challenges the illusion of control and even the claim of omnipotence of scientific knowledge. The most frequent causes of IUFD are obstetric (placental abruption, placental abnormalities, cord abnormalities), maternal (infections, diabetes, hypertension) and foetal (genetic malformations). In 25% of cases, the cause of intrauterine death remains unknown, making it even more difficult for parents to make sense of their grief. In some cases, only genetic testing, many months later, can provide useful answers to help interpret the event. Perinatal death, as a disruption of a life plan and of individual and couple psychological continuity, takes on the characteristics of trauma. As such, it is associated with the emotional reactions typical of trauma: shock, dissociation, denial, anger, guilt, intrusive thoughts and flashbacks. International scientific societies have developed specific guidelines containing evidence-based clinical behaviour recommendations that provide for a multidisciplinary team consisting of gynaecologists, geneticists, midwives and psychologists to support parents in cases of IUFD (RCOG 2020; ACOG, 2020; SIGO, 2023). The presence of a psychologist is necessary at various stages:

1) Diagnosis of IUFD
2) Preparation for childbirth
3) Postpartum

4) Couples therapy for grief processing

With this work, based on my twenty years of experience in the Maternal and Child Department of an Italian hospital, I will briefly focus on the first three points listed, referring to the guidelines (SIGO, 2023) for further information. Instead, I will focus on the last stage of the process (point 4), which involves couples' psychotherapy for grief counselling.

1) ***Diagnosis of IUFD***

IUFD is often diagnosed in the obstetric emergency room, where couples seek help when abnormal absence of foetal movements during pregnancy persists. In other cases, the diagnosis is made during a routine pregnancy check-up. Only in a few cases does it follow a diagnosis of foetal pathology or severe distress. At the time of diagnosis, the couple experiences a state of shock. The emotions that parents experience include confusion, bewilderment, guilt, shame, despair, anger and helplessness. From the second trimester onwards, after prenatal screening (Bi-Test, Prenatal SAFE), couples begin to invest psychologically in the baby, giving it a name and imagining it. The construction of the representation of the imaginary (Soulé 1980) or phantasmal (Lebovici, 1983) child begins in a more concrete way. From the 22nd week of gestation, foetal movements begin to be clearer and more perceptible, and we no longer speak of abortion but of foetal death or stillbirth. Psychologically, the loss of the foetus represents a real bereavement, as it concerns a person with whom an emotional bond is being formed. In the first interviews with couples, narcissistic investments (fantasies, projections) emerge. Pregnancy loss affects unconscious identifications, the narcissistic contract (Aulagnier, 1975), and the meaning that the child takes on in the couple and in the family depending on the specific moment in the developmental cycle. For couples who already have children, the central question is how to communicate the terrible news to their other children. The answer given varies depending on the child's age, level of awareness and involvement in the pregnancy. In many cases, with children over the age of 5, it emerges that the little brother or sister was wanted and asked for by the older sibling. The first interview therefore takes on the significance of a brief but very intense first entry into the deeper family dynamics. In the conscious and unconscious fantasies and representations that the couple and the family were building around the child.

2) ***Preparation for childbirth***

In most cases, drug-induced labour is recommended, both to facilitate postpartum recovery and to allow for a subsequent pregnancy. Only in some cases is a caesarean section recommended. Preparing for separation, letting go of the baby, giving birth to a stillborn foetus is one of the most traumatic experiences for a woman who

experiences the disturbing, intolerable closeness between life and death. Giving birth coincides with the darkness of loss. Many women during childbirth, unable to accept the loss and separation, unconsciously try to hold on to the baby in an attempt to deny the terrible reality and preserve the omnipotent illusion of being able to protect it inside their own body. The induction process is thus painfully prolonged, lasting up to 2-3 days. Many studies document the profound interconnection between mind and body at the psycho-neuro-endocrine level. High levels of cortisol, produced in response to fear and stress, inhibit the production of oxytocin. If the woman does not let go of the baby psychologically, if she does not acknowledge the death of the foetus and the unbearable reality of powerlessness and loss, labour will not begin. In many cases of IUFD, where labour is prolonged due to dissociative reactions (freezing), teamwork with the midwife allows women to let their emotions flow and move on to active labour, enabling them to give birth to their baby. The presence of a psychologist in these cases is necessary because, in synergy with the midwives, the somatic aspects can be integrated with the psychological ones in order to create a safe and welcoming environment in which the couple, and the woman in particular, feel they can give in to their emotions of sadness and despair and, sometimes through crying, release the emotional block in order to prepare for childbirth.

3) ***Postpartum: to recognize and let go of the newborn***

After the birth, is endorsed (guidelines) that parents see their newborn baby: this gives them the opportunity to "say farewell", hold them in their arms in a private and protected environment and keep a tangible memento of the baby (clothes worn, footprint) to be kept in a so-called Memory Box. This practice, like all burial rituals, has the psychological function of allowing the child to be recognised as one's own, maintaining continuity with the pregnancy and at the same time initiating the process of differentiation-separation between the real child and the imagined child and beginning the mourning process. The work of mourning, as Freud (1917) taught us, begins when the subject is forced, under the pressure of reality testing, to acknowledge the inexorability of the loss and the consequent need to begin a gradual withdrawal of libidinal investment from what concerns the lost object. Before Freud, the poet Foscolo wrote in *Dei Sepolcri* (1807) that the grave allows for the "correspondence of loving feelings" that binds the deceased to their loved ones and allows them to overcome the fear of oblivion. This seems particularly significant in the case of intrauterine deaths, where we can speak of an intimate, secret mourning for the couple because it is difficult to share on a social level. The only traces of the child's presence, of the fantasies and dreams created during pregnancy, remain in the mother's body, in her feelings and thoughts, and in the plans made with the father.

Over the years, clinically, I have come to understand the importance of this transition. I still remember the words of a highly experienced midwife and her story of a woman who, having suffered perinatal bereavement and unable to find comfort, had developed pathological grief or melancholia over time. When, many years later, a relative showed her a photo of the newborn, which had been kept secret for fear of worsening her condition, the woman was finally able to process her grief, letting go of the "persecutory ghost" of that child she felt she could not forget, having fallen into a mechanism of repetition compulsion, fuelled by guilt and shame. In such cases, the ego identifies completely with the lost object. The shadow of the object falls on the ego, which remains "impoverished" and emptied, as the narcissistic and ambivalent relationship with the object hinders the normal course and overcoming of grief. In the melancholic person, there is a mortification of self-esteem, associated with a feeling of persecutory guilt and self-accusation (Freud, 1917).

In my experience, the early stages following a diagnosis of IUFD are very important for the grieving process to evolve physiologically. Sometime later, many couples returned to the hospital to thank the staff for giving them the opportunity to say farewell at the time of their loss, which had allowed the couple, albeit for a few brief moments, to consider themselves as the parents of the child they had imagined and dreamed of during the pregnancy. In many cases, the burial ritual, whether religious or secular, also becomes a time to care for the child, to devote attention to them and to remember their presence within the family history.

4) *Couples therapy for the grieving process*

In institutional clinical settings, after the initial counselling phase, which, as described, consists of three phases (diagnosis, preparation for childbirth, and farewell), couples are offered a brief therapy program to support their grief process. This program typically consists of 12 sessions, scheduled for about six months, and is held every two weeks. Alternatively, couples who do not wish to return to the hospital, as it is a place burdened with memories of the loss, are offered the option of referral to territorial services (family counselling centres). In recent years, most couples who were able to receive psychological support and counselling immediately after diagnosis have decided to continue their treatment in the hospital. Depending on the couple's relationship, the program may conclude after the series of sessions required for brief focal psychotherapy (12 sessions) or become a full-fledged couples therapy. This type of intervention, in an institutional context, when carried out promptly after the traumatic event, aims to promote the mental health of couples both horizontally by protecting the couple's bond, and vertically by preventing the transgenerational effects of unresolved grief within the family (Keogh, 2024).

During the initial interviews with couples, the event most often mentioned is the death of a relative, particularly a parent, if it occurred when one of the partners was still growing up.

Feelings of helplessness are reactivated, as are, in some cases, the defence mechanisms activated at the time: denial, detachment, escape into mania, etc. Understandably, men and women react differently to IUFD. For women, there is a greater emotional involvement related to internal sensations (foetal movements, internal dialogue between mother and foetus), which leads to difficulty integrating the bodily aspects related to the transformations of pregnancy and the postpartum period. The absence of the child is physical, corporeal: "the belly is missing". For men, who very often become fathers when they hold their child for the first time, mechanisms of denial and avoidance prevail.

I recall the case of a father who, upon hearing the news of his daughter's loss, acted out his need to escape the pain. He refused to see the child. Only during the interview was it possible to bring to light the memory of his father, who had died when he was 20 and whom he had been unable to see because he was studying abroad. Only then was it possible to differentiate between the two losses. In this case, working with the couple allowed both parents' fantasies and investments in the child to surface, highlighting both shared elements (at the intrapsychic level), or behaviours constructed through the couple's bond (at the interpsychic level).

In other cases, its traumatic events, secrets from family history that resurface. Like an earthquake, it can uncover secrets buried for years, often laden with unresolved emotions and fantasies. I remember a woman in her third pregnancy who, to avoid overly medicalizing the birth and experience it intimately with her husband, had chosen to give birth in a maternity home assisted only by a midwife. When she discovered a missing heartbeat, she was urgently transferred to the hospital. During the induction, the woman told me about her maternal grandmother, who, as a teenager in the 1960s, had been raped in a small town in Southern Italy. Out of "disgrace" and social shame, she was forced to move to another city to give birth to her child. During our conversation, the woman's associations helped us connect the experience of induced birth to the rape and the meaning it had taken on in her family history: the inability to choose one's own life; undergoing a birth not as a chosen, joyful event, but as a violent imposition.

After this story, I was able to better understand why this woman initially chose not to give birth in a hospital, but in a warm, intimate place, like a maternity home, with the assistance of a protective female figure. As I got to know this couple, I was struck by the fact that she had chosen a much younger partner, a "child-like" husband, less threatening than her inherited unconscious representation of men as intrusive and violent. Therapy with the couple revealed an asymmetrical bond that began shortly after the death of the husband's mother, and this led to the wife assuming almost a

surrogate maternal role for her husband. This bond came into crisis with the birth of their first child, when the wife experienced a period of postpartum depression and felt unsupported and emotionally disengaged from her husband. The wife subsequently began individual psychotherapy, but the issues surrounding the couple's bond were not addressed. During the grief therapy process, the defence mechanisms of both spouses with respect to pain emerged and the spouses were able, for the first time, to experience a bond capable of containing psychological suffering and capable of protecting the first two children from the negative effects of the loss.

Very often, childhood bereavements that have marked the family's history are reactivated. I remember a father who, during his first interview, spoke of the trauma his family of origin had faced before he himself was born: the birth of a baby girl with malformations caused by the drug "thalidomide", frequently prescribed in the 1960s to treat nausea during pregnancy and later withdrawn because it was teratogenic. Despite never having met this little sister, this man described how many events related to her birth and short life remained secret in an attempt to hide an unconscious guilt. This guilt was passed on to his other children born subsequently, in the form of intense anxiety and worry about their health. The only associated memory is the image of his father counting the fingers of every newborn he met (phocomelia resulted in agenesis of the fingers).

In these cases, a recent traumatic event can allow the family's traumas and secrets to be given a new meaning on a transgenerational level, giving voice and words to that pain that had remained silent, unthought, and had continued to work in the family's unconscious.

Theoretical framework

In the literature, 20-30% of women who have suffered a perinatal loss experience depression, anxiety and post-traumatic stress disorder one year later. Unprocessed grief is associated with a higher number of divorces and separations in couples (Ford & Slust, 2009) and has an impact on the development of children, with the possible activation of a chain of relationship breakdowns and losses that can reverberate across generations (Faimberg, 2005). Timely psychological intervention is essential to reduce the pathological evolution of unprocessed grief (Rosner & al., 2011). Psychotherapy with the couple and family can reduce the long-term effects of unprocessed grief resulting from intergenerational transmission (Keogh et al., 2019). The psychoanalytic model, based on object relations theory and integrated with link theory, represents the cutting-edge approach to couple and family psychotherapy and psychoanalysis (Scharff & Palacios, 2017). In its clinical application, this focuses primarily on working with internalised relationship patterns (self-object relationships) or internal bonds, which make loss difficult to process. Secondly, it

focuses on how unconscious inter-subjective bonds, which are also dynamically constructed with the analyst in the here and now (Kaës, 2001), can act as transformative "interference", analysing the aspects projected onto the analyst or partner through countertransference. This approach can help highlight the impact of loss at an intergenerational level in so-called "disruptive vertical bonds" (Faimberg, 2005).

In psychoanalytic couple psychotherapy, proposed in an institutional context, we chose to use the Italian model (Nicolò & al., 2021), which, starting from Pichon Riviere's (1980) concept of bond (vinculo), considers this as a third element, between the intrapsychic and the intersubjective, co-constructed by both members of the couple. According to this model, the bond concerns not only intrapsychic dynamics but also the communicative and relational dynamics of the couple.

Bonds always have an acted side and can therefore be observed more in the actions, behaviours, non-verbal language or bodily manifestations of the members (Nicolò, 2015). Great importance is given in clinical work to myths, dreams and memories narrated in the family, but above all to coordinated interactions in the family in interactive, unthought habits. Here lie the fundamental constructs of psychic life, unprocessed traumatic memories are transmitted and relational rules learned unconsciously from other generations and renegotiated in the new family are repeated. From this perspective, the traumatic event, bereavement, impacts the couple's bond through transpersonal defence mechanisms. Therefore, the aim of this intervention is to support the couple's bond so that the destructive forces, the result of the couple's primitive mechanisms of splitting and projection, are contained, while also activating the reparative functions and the ability to contain and symbolically represent mental suffering (Melzer & Harris, 1983).

Defence mechanisms and couple link: Between maniacal defences and melancholia

The quality of the link built within the couple, as well as the personality structure of the individual partners, can influence the mourning process. Very often, the death of a child is experienced as a narcissistic wound, a failure that leads to a lack of control and a feeling of helplessness that is difficult to tolerate. In these cases, the need to obsessively repair the loss through another pregnancy can become an obsessive thought (*replacement child*, Reid, 2007). For these couples, even accessing therapy in a constructive way becomes difficult: unable to process the sense of emptiness, narcissistic anger, a sense of injustice for the wrong suffered, and the need for redemption prevail. The desire for parenthood is replaced by the need for narcissistic validation: the void must be filled immediately, so much so that just a few months after the bereavement, the return of the menstrual cycle is intolerable, and every

month a wound reopens, signalling the absence of the pregnancy. Not unlike couples who experience the assisted reproductive technology (Marion, 2017), the search for pregnancy becomes a way of repairing a fragile self.

The therapist's countertransference may be characterized by ambivalent feelings, of tenderness and frustration, due to the repetitive nature of the content presented, which concerns the obsessive pursuit of a new pregnancy. There is no room for processing emotions, feelings of emptiness and loss. In these cases, with couples who have concrete thoughts and difficulty constructing shared symbolic representations, the therapeutic process is particularly challenging.

In other cases, however, depression and melancholy prevail, particularly in women: grief is linked to feelings of guilt and shame for not having protected the child. This condition can undermine the couple's bond, especially when combined with denial mechanisms and possible manic defences implemented by the partner, who focuses exclusively on work and social routines because he is unable to share the most painful phases of grief and the sense of emptiness and sadness his wife is experiencing. Frequently, in these cases, women may experience annoyance, if not outright hatred, masking envy toward other pregnant women. This can lead to avoiding social situations where they might encounter pregnant relatives or friends or those with small children. The couple becomes socially isolated, feeling withdrawn and alienated: the drama of the loss of their child becomes central and dominates their entire lives. No one is able to understand their pain; family members and close friends are distant; the deadly dimension invades the space of their bond. Pathological mourning becomes a picture of transpersonal distress, which invades the couple's bond and intersubjective space.

In other cases, grief becomes more complex if it signifies a breakdown in the couple's idealized plan. For example, in couples with older partners, divorces, and previous dysfunctional relationships, a late pregnancy, sometimes unplanned or even achieved through assisted reproduction, takes on an ideal, life-saving function and confirms the exceptionality of the bond. The magical child is attributed with the task of representing a new beginning, a new life for both partners. Particularly for some women, if they are already mothers, the child can represent a gift offered to their partner as the seal of the ideal family, serving to repair past suffering and pain. The loss appears twofold, as it is associated with the guilt of not having defended and protected the child, but also with the guilt of not having given a child to the new partner and not having made him a father.

Containing the suffering and repairing the link

The case I am going to present highlights how the technique of working on dreams, on narratives, the analysis of the co-constructed link between the couple and the analyst, the analyst's *reverie* are fundamental tools in psychoanalytic therapy with couples.

Chiara and Francesco are a couple between 35 and 40 years old, with a strong and lasting link, based on shared ideals and interests. The decision to have a child was widely discussed: initially, the husband didn't feel ready to become a father, while she expressed a strong desire to be a mother. After a peaceful pregnancy, they reached the 38th week of gestation, and as the due date approached, like all couples, they formulated plans and dreams, taking care to carefully prepare everything they needed. They chose a name for the baby, associated with a person who was dear to Chiara during her childhood. After a few hours of no foetal movement, they decided to go to the hospital, and while waiting in the emergency room, the terrible news arrived: no heartbeat.

At birth, they discovered that their baby was perfectly healthy. Tragically, she had a very long umbilical cord: the doctor found two knots in the cord and five twists around her neck. After the birth, they were devastated by the pain but grateful for the opportunity to experience an intimate moment of being parents to their daughter.

A few weeks after the event, they asked me to continue psychological sessions offered in these cases by the Hospital's Psychology Unit, through a series of 12 meetings, held every two weeks. In the first few months, elements of both their personal and family histories have emerged. Their individual weaknesses and resources, as well as the co-constructed couple bond, we began to understand. After a few months, the grieving process has become more complicated, and the suffering began to manifest itself physically: Chiara began to lose excessive weight, while Francesco suffered several accidents and illnesses that forced him to stay home. Their bodies, increasingly marked by pain, expressed their difficulty moving forward, rediscovering the meaning of their lives and their togetherness. Their daughter's death has frozen their existence; they felt unable to find pleasure and enthusiasm for anything, despite a previous life rich in relationships and interests. Chiara began to withdraw from her social work, which she had built with passion and dedication. They experienced moments of profound sadness that turned into anger, resulting in heated conflicts that threatened to undermine the couple's bond. I proposed increasing the frequency of their meetings, which have become weekly. Gradually, the content of Chiara's anger had become clearer, associated to persecutory thoughts toward the female figures in her husband's family. Chiara's anger seemed to cover the void of the original narcissistic wound. She became verbally abusive and demeaning toward her partner, even in sessions. She accused

him of not protecting her from his family and, indirectly, of potentially not being a good father capable of defending a child.

On a countertransference level, I sensed a strong concern, particularly for Chiara, whom I perceived as suffering greatly. I sensed that their relationship was in danger, but I also sensed that there was more going on beyond the mourning. Something about their link eluded me. At the same time, her husband's fragility emerged, and I saw him "fall to pieces" (he broke an arm, then a leg, within a few months). At times, I sensed that Chiara's hatred was powerful and destructive, threatening to destroy everything they've created together. Initially, I hypothesized that Chiara's wife is questioning her husband's paternal capacity as a displacement of her persecutory aspects of guilt and inadequacy related to the loss of their child. I realized, however, that this interpretation was partial. I agreed to be with them in uncertainty, to not know, to use my negative capacity, and to give space to *reverie* (Bion, 1962) in the sessions. I perceived that the couple's transference was still managing to contain their anxieties; they appeared relieved after each session: they told dreams and reflections, whereas when for some reason a session was cancelled, they felt the lack of them, returning as if fragmented. I wondered what place I, as a therapist, was occupying on a symbolic level in the couple, and I felt that perhaps for both of them I have taken on the role of a grandmother, a "wise" person who welcomed them without judgment. I remembered then that the little girl was named after her maternal grandmother. I thought of the need for protection and security that a grandmother can offered, providing a warm and welcoming refuge, made up of familiar sensations, good food, time, care, and a listening ear. A grandmother who provided comfort during the storm of suffering. A dream of Chiara's opened up new readings of the couple's conflict: "*Chiara was supposed to go on a humanitarian mission to an Eastern European country to help a family in need, consisting of a mother, an older daughter, and younger children. The family was in dire straits, but she realized that after her initial tenderness toward them, she began to resent the family dynamics they were trying to involve her in. She decided to leave and become a Russian spy, a very sexy woman with black bob hair, bright red lipstick, and a thin cigarette between her fingers. In the dream, her husband was an accomplice in the espionage, but he was unattractive; he was bald, unkempt, and had a paunch. They were supposed to be playing a double game, selling classified information to the Russians".*

I asked both of them to associate with the dream. The associations led back to Chiara's family of origin, consisting of her parents and two daughters, of whom she is the youngest. Chiara described her mother as lacking affection (the poor family) but controlling towards her and absorbed in a symbiotic relationship with her sister, "the perfect and favourite daughter". Thus, it emerged that the jealousy and envy originally felt towards her own mother and sister is displaced onto her husband's mother and sister, unconsciously accused of being very close to each other and of

being insensitive to her grief over the loss. The associations revealed a female triangle (mother-sister-Chiara) from which Chiara constantly feels excluded, inadequate, and unchosen. A loving but ineffective father figure also emerged, one who failed to "protect" her and to invest her narcissistically. The dream depicted a couple's relationship, in which she was described as a sexy and detached spy, phallic and aggressive, while he appeared as a very devalued figure, like unattractive man. The husband emphasized that in the dream the couple is playing a "double game"; they associated it with something false, inauthentic, or with how they pictured their current lives. The associations also revealed a libido, understood as complicity as well as sexuality, clouded by her experience as overly demanding, even sexually. He appeared more passive and apathetic. Sexuality aimed at procreation had become performative and full of expectations, thus anti-erotic and inhibiting for the husband. In working with the couple, it gradually emerged, at an intrapsychic level, that behind the conflictual dimension, with references to the Oedipus complex and the fraternal complex (Kaës, 2008) characterized by feelings of envy, exclusion, and vindication, lie deprived pre-Oedipal aspects. Chiara chose a partner who had nurturing characteristics and, in some ways, mirrored her father's more maternal ones. At the same time, however, she perceived him as unmanly and not very "protective". Francesco was able to develop a particular emotional sensitivity: he cared for his mother, who had suffered from depression since his childhood. This made him a gentle and sensitive man and inhibited his aggression, so much so that he appeared weak and passive to his wife. Approximately nine months after the beginning of therapy, it emerged that Chiara was born slightly premature and with an extremely low birth weight. Hospitalized in the Neonatal Intensive Care Unit (NICU) for a month, her mother was only allowed to visit her for one hour a day. Her mother always told her that she was ugly when she was born, and this caused her to identify with the "rejected" part, the "badly formed daughter". As a teenager, she developed eating disorders and self-harm. The much-desired yet tragically denied pregnancy served as a reparative measure for aspects of childhood deprivation. She unconsciously needed to become the warm and welcoming mother she doesn't felt she ever had. In this sense, the loss of her daughter caused a deep narcissistic wound capable of reactivating the original trauma. During a session in which the wife discusses the conflict with her husband, she says:

C. *"He doesn't protect me from his mother and sister. I don't feel like he's on my side, I feel alone, I feel like he doesn't understand me. So, I get angry at him and say terrible things to him. I know he's not mean, that he loves me, but it's stronger than me. I feel like nothing makes sense anymore, sometimes I have terrible thoughts, as if our relationship has no meaning anymore, and neither does my life."*

F. "In these moments, C. accuses me of everything, and I feel like I'm wrong. That I'm worthless as a partner and a father. Yet I think I'm a sensitive person, used to questioning myself. But this pain doesn't go away. I feel like it's driving us apart."

T. "Perhaps Chiara feels alone, abandoned in her pain, just like when she was a newborn baby. She feels wrong again, unworthy, for not having been able to realize her dream of becoming a mother."

(I note that Chiara begins to tremble, shivers shake his skin. I imagine her in an incubator like the newborns I saw when I was working in the NICU. As if her body felt all the cold of a creature born into the world with thin skin, without protection. At this point, Francesco approaches Chiara, holds her hand and caresses her gently, looking into her large, luminous eyes. We share a moment of great emotion and emotional connection.)

Addressing both of you I say: *"Maybe Francesco is trying to be close to her, but he feels that sometimes he can't do it the way she would like, that there's like a screen between you and she feels alone and abandoned*".

This brief passage reveals how, at the intrapsychic level, the mechanisms of projective identification of primitive abandonment and destructive aspects (beta elements; Bion, 1962), reactivated by the loss, were undermining the couple's relationship. The bond co-constructed by the couple was based on an omnipotent fusional demand, founded on the illusion that the relationship could undo the pain, loss, and separation experienced by both in childhood. In the session, in the here and now at the interpsychic level, through the bond, between the partners and with the therapist, through reverie, a profound communication occurred, in which both felt welcomed in their subjective suffering. The body's signals gave voice to a contact that was not only verbal and cognitive, but also corporeal and sensorial, providing access to the unrepresented primitive states of the mind (Levine, 2015) that released profound, original, and unthinkable emotions.

As Mary Morgan (2021) reminds us, the analyst's task is to maintain a "couple's mental state". This internal state, for the analyst, consists of preserving in his or her mind the functioning of both partners and their ways of relating. In this way, he or she can perform the therapeutic function of containment, restoring to patients a vision of their mutual bond.

The couple has begun planning together again: they've envisioned a nature vacation where they can walk and rediscover their rhythm, listen to themselves, and rediscover the joy of sharing. Arguments and conflicts have diminished. There's still a long way to go, but the couple seems to be beginning to manage their suffering and share emotions and hopes.

The function of myth

Vanessa and Lucio are a couple in their 40s. They appear very much in love. They have a beloved 3-year-old son, and both come from very close families. She has decided to move to another city and quit her job to take care of her family, which is their priority in life. Stillbirth upends their plans for a large family, and their primary concern is for their first child and how to communicate the bad news. Upon returning home after giving birth, the baby shows a slight regression: he wants to spend more time with his mother, complains when she leaves, but then resumes his life, school, and play. Vanessa experiences her moments of sadness alone and suggests to her husband, who is initially reluctant, that they meet me at the hospital so they can share their emotions. The baby is at home, and to protect him, they avoid talking about it. During the discussions, it emerges that the wife is struggling to return to normalcy, to tell the people who saw her pregnant about the loss of the child. Pregnancy is an event that cannot be hidden; it has a social significance. The loss of a child is even more so: the absence of a child forces couples to justify and explain what has happened. Vanessa explains with difficulty that she's avoiding people for fear of having to tell them what happened and "of having to deal with others' reactions of embarrassment in the face of the unbearable grief of losing a child". After months of isolation and confinement, Vanessa decides to return to her hometown and revisit her family of origin. This opens the possibility of reworking the grief, which, from a private event, becomes something that can be shared and reworked at the family level, through the mythopoetic function of family narratives (Nicolò, 2014). Thus emerges the story of Vanessa's maternal grandfather, who in the 1950s, when home births were still common, had to provide burial for the tiny body of a stillborn child. The image of a mythical figure emerges, a man who, on foot through the snow, holding the tiny body of this child wrapped in blankets in his arms, crosses the town until he reaches the cemetery where the priest is waiting to perform the burial. At the same time, the husband also recounts that his mother, who had six children, Lucio being the youngest, had lost a child near the end of her pregnancy after the first three. The story of this perinatal grief is connected to other losses experienced across generations: it is now possible to enrol this child in a family tree capable of embracing the living and the dead through those profound bonds in which the couple's pain and suffering, if shared, can be given a new meaning within a broader evolutionary journey across generations.

Start hoping again

The work of supporting couples in grieving is often very challenging because it requires the therapist to be in touch with death and suffering, and to constantly

monitor their own countertransference, their own grief, worked through over years of analysis, their parenting, and the various identifications with a parent's deepest anguish. But in some cases, it also brings unexpected joy, the miracle of budding hope, of life reborn. Many couples return after a long time to share a new pregnancy or the birth of another child. The role of couples therapy becomes to contain and process the pain so that the creative and transformative aspects of the couple can resurface after the storm.

After an initial six-month grief process, a couple returns a few months later at the beginning of a new pregnancy. They ask for support to manage their anxiety and allow them to experience the pregnancy without the shadows of their previous loss. The dreams in the early months, particularly distressing and focused on losses and malformations, hark back to the previous trauma, but at a certain point, toward the end of the pregnancy, the wife recounts this dream that opens up hope. "*There was a new house I didn't know. I walked down a long, dark corridor. At the end, there was a room filled with light and a large bed where small children of different ages played"*.

Sharing with the couple the emotion of this dream that signals the rebirth of hope, of life, I thought of the words of the poet Tagore:

"*Tempest roams in the pathless sky,*
ships get wrecked in the trackless water,
death is abroad and children play.
On the seashore of endless worlds
is the great meeting of children".

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