When the Body Speaks What the Mind Cannot Bear

A Biopsychosocial Approach to Perinatal Grief, Infertility and Somatisation

by

Eusebiu Jean Tihan and Mihaela Laura Tihan

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Preface

Why this book?

We wrote this book because we felt there was a need for a bridge. A bridge between the world of medicine, which sees hormones and biological markers, and the world of psychology, which sees emotions and narratives. A bridge between the visceral pain of losing a child in the perinatal period and the often silent, invalidated pain of losing a companion animal or of chronic infertility. A bridge between theoretical understanding of pain and practical intervention, between case study and clinical trial, between the therapeutic consulting room and public policy.

This book was not born in the ivory tower of academia. It was born from two sources: from our personal pain – the loss of Maya, our fourteen-and-a-half-year-old husky, who taught us more about attachment and grief than any textbook – and from the pain of our patients, who entrusted us with their stories and allowed us to learn from their suffering.

We wrote it for the clinician who often feels helpless in the face of a patient with chronic pain following a perinatal loss, unsure how to connect the two. We wrote it for the researcher seeking appropriate methods to study an object that cannot be experimentally manipulated – grief. We wrote it for the bereaved parent who hears that they can 'have another child' and feels invalidated in their deepest pain. We wrote it for the father who cries in silence, because society has not offered him a place for his tears.

Finally, we wrote it for ourselves – to understand what we did not understand, to name the pain we felt, to transform personal suffering into a working tool that could help others.

Who is this book for?

This book addresses a broad audience, but is structured across several levels of depth.

For clinical psychologists and psychotherapists, this book offers an integrative theoretical framework for understanding perinatal grief, infertility and associated somatisations, as well as practical intervention tools – from the 'Reclaiming the Body' protocol (integrating psychodrama, somatic therapy and EMDR) to couples therapy focused on the trauma of loss.

For physicians – especially endocrinologists, obstetricians, general practitioners and internists – the book offers an accessible introduction to the psychosomatics of grief, explaining why a patient with hyperprolactinaemia following a perinatal loss does not necessarily need cabergoline, but may need to be listened to. It also offers practical guides for anamnesis and interdisciplinary collaboration.

For researchers, the book offers a map of research methods in the psychosomatics of grief – from case study to randomised clinical trial – as well as a detailed protocol for a future RCT to test the efficacy of the proposed interventions. It also offers a research agenda for the next ten years, with clear and feasible priorities.

For policymakers and public health professionals, the book offers an analysis of how labour legislation, the healthcare system and cultural taboos validate or invalidate perinatal grief, as well as concrete reform proposals – from including perinatal loss in bereavement leave to national hospital protocols.

For bereaved parents and the general public, the book offers an understanding of their own suffering, a language to name it, and hope – that pain can be transformed, not merely endured. The chapters on pet grief and on infertility are written in accessible language, and the

essayistic conclusions of the final chapter offer informed consolation, not merely simple solace.

How to read this book

The book is structured in four parts, which can be read independently but together form a coherent arc.

Part 1 – Theoretical and personal (intimate) foundation – provides the conceptual framework of the work. It begins with a narrative-explanatory analysis of pet grief (Chapter 1), which serves as a model for understanding socially disenfranchised grief. It continues with a history of the epistemology of pain (Chapter 2), from Hippocrates' humours to twenty-first-century biomarkers. It then presents the neuroendocrine triad of attachment – cortisol, oxytocin and prolactin – and how their chronic imbalance underlies functional hyperprolactinaemia and complicated grief (Chapter 3). Chapter 4 focuses exclusively on prolactin as a 'translator' of psychological suffering, analysing the associated psychological profile (hyper-responsibility, diffuse boundaries, inhibition of aggression) and specific psychotherapeutic interventions. Chapter 5 introduces the theme of perinatal grief in fathers, anticipating the distinction between 'silent presence' and 'invalidated absence'.

Part 2 – Case studies and the dynamics of suffering – applies the theoretical framework to concrete cases. Chapter 6 analyses two cases of perinatal grief – one urban, educated, leading to marital cohesion; the other rural, with limited resources, leading to pathological disintegration. Chapter 7 develops the theme of paternal grief in depth, presenting two polar models of response – adaptive ('silent presence') and maladaptive ('invalidated absence') – and offers adapted psychodramatic techniques. Chapter 8 makes the transition from perinatal grief to chronic infertility, introducing the concept of captivity-type stress and its neuroendocrine correlations with prolactin. Chapter 9 generalises the psychosomatic model to other types of loss – from chronic pain to autoimmune diseases, from metabolic pathology to broken heart syndrome.

Part 3 – From theory and narrative to method and intervention – offers practical tools for research and intervention. Chapter 10 analyses research methods in the psychosomatics of grief – from case study to randomised clinical trial – and proposes a research agenda for the next ten years. Chapter 11 presents the 'Reclaiming the Body' protocol, an integration of psychodrama, somatic therapy and EMDR in the treatment of functional hyperprolactinaemia and perinatal grief. Chapter 12 offers a framework for trauma-focused couples therapy, analysing the five major dysfunctional patterns and specific techniques to transform them.

Part 4 – Context and vision (widening the horizon) – looks outward, towards society and the future. Chapter 13 analyses the politics of disenfranchised pain – bereavement leave, the healthcare system, cultural taboos, the therapist's role as advocate – and proposes concrete reforms for Romania. Chapter 14 offers an intercultural study of perinatal grief, comparing urban with rural settings, Romania with other Eastern European countries and with Western countries. Chapter 15, the final chapter, is an essay proposing a new paradigm of suffering – from patient to person, from symptom to narrative, from cause to meaning, from treatment to accompaniment.

A note on style and method

This book is not afraid to interweave different registers. You will find, side by side on the same pages, citations from randomised controlled trials and personal reflections on the death of a dog, statistical analyses and clinical stories, therapeutic protocols and philosophical questions. This is not inconsistency – it is a methodological choice. Suffering is not disciplinary. It does not recognise the boundaries between neuroendocrinology and psychoanalysis, between clinical psychology and public policy. The tools we use to approach it must be as integrated as it is.

You will also find an explicit reflexive positioning. Instead of claiming detached objectivity, we acknowledge that we write from a particular

position – that of clinical psychologists who have themselves experienced significant losses. This acknowledgement does not weaken the scientific authority of the text – on the contrary, it grounds it on a more honest basis. There is no outside perspective in the study of suffering. We are all inside it.

Acknowledgements and gratitude

This book would not have been possible without the help of many people. First and foremost, we thank our patients – those who entrusted us with their stories and allowed us to learn from their suffering. We thank our medical colleagues – endocrinologists, obstetricians, psychiatrists – who opened the door to the neuroendocrinological understanding of pain. We thank our supervisors and trainers – in psychodrama, in EMDR, in somatic therapy. We thank our family and friends who supported us during the times when writing this book meant reliving our own pain. And, finally, we thank Maya. For fourteen and a half years of pure love. For the lesson of secure attachment. For the peace you left us as inheritance.

Laura Mihaela Tihan and Eusebiu Jean Tihan
Bucharest, 2026

Introduction

From paw prints to broken heart

There is an image that has stayed with us throughout the writing of this book. It is the image of a mother who, after losing her child in the perinatal period, stands before the mirror and looks at her body – the same body that housed a life, the same body that now produces milk for a child who no longer exists. Her body does not 'know' that the loss has occurred. Her hormones continue to prepare the ground for a pregnancy that will not come. The milk flows. And in this discrepancy between external reality (the child is no longer here) and internal reality (the body behaves as if it were still there), pain finds a place to dwell.

This image is, in essence, what this book seeks to understand: the way in which psychological suffering becomes somatic suffering, the way in which untreated grief does not disappear but transforms – into raised prolactin, into chronic pain, into autoimmune disease, into broken heart.

Why a new book on grief?

The literature on grief is vast. From Freud and 'Mourning and Melancholia' (1917) to Bowlby and attachment theory, from Kübler-Ross and the stages of grief to Worden and the tasks of grief, from psychoanalytic models to neuroendocrine studies – there is an abundance of knowledge. And yet, there are gaps.

The first gap is integration. Neuroendocrinology speaks of cortisol, prolactin, oxytocin – but rarely connects these molecules to the subjective experience of loss. Psychoanalysis speaks of internal objects, symbolisation, the depressive position – but rarely connects these concepts to measurable biomarkers. Clinical practice speaks of interventions – but rarely connects interventions to the underlying

neuroendocrine mechanisms or to the social context in which they occur. This book attempts to build these bridges.

The second gap is specificity. Most books on grief treat loss in general terms, as if all losses were alike. But the loss of a companion animal is not like the loss of a child. The loss of a child in the perinatal period is not like the loss of a ten-year-old child. The loss of fertility is not like the loss of a real child. Each type of loss has its own particularities – in terms of social recognition, capacity for symbolisation, somatic manifestations. This book analyses these particularities in detail.

The third gap is contextualisation. Most books on grief are written from a Western, urban, educated, secularised perspective – and assume that this context is universal. But grief is not the same in urban and rural settings, not the same in Romania and in Sweden, not the same for an educated person and for one with limited education. This book includes a detailed intercultural analysis and recommendations for a less ethnocentric clinical practice.

The fourth gap is politics. Most books on grief stop at the threshold of the consulting room. They do not ask: why does a parent who loses their child at birth not have the right to bereavement leave? Why are the remains of a foetus treated as 'medical waste'? Why is psychotherapy for complicated grief not reimbursed? This book includes an analysis of these policies and concrete proposals for reform.

The three bridges of pain

The theoretical structure of this book rests on three major 'bridges', connecting the biological plane to the psychological and social planes.

The first bridge – the neuroendocrine bridge – shows us that grief has a measurable hormonal cost. Cortisol, the stress hormone, remains elevated in complicated grief. Oxytocin, the attachment hormone, drops sharply after a perinatal loss, leaving the mother without her 'buffer' against

stress. Prolactin, the lactation hormone, continues to be secreted even when the child for whom it was intended is no longer there – a 'phantom lactation' that can persist for months. These biomarkers are not 'causes' of pain – they are translators of it. They make visible what would otherwise remain invisible, offering a biological argument for suffering that would otherwise be invalidated.

The second bridge – the psychoanalytic bridge – introduces the concept of 'capacity for symbolisation'. Integrated grief involves transforming the lost object from a persecutory ghost (which haunts and tortures) into a loyal presence (which dwells in the heart and illuminates). This transformation is only possible through symbolisation – through finding words, images, gestures, rituals that represent the loss in a way that makes it bearable. Failure of symbolisation leads to somatisation – pain migrates into the body and becomes chronic pain, autoimmune disease, obesity, metabolic syndrome.

The third bridge – the socio-cultural bridge – shows us that the recognition or non-recognition of loss by the community has a massive impact on the trajectory of grief. The concept of 'disenfranchised grief', introduced by Kenneth Doka, describes those losses that are not publicly recognised, validated or honoured. When loss is validated – through bereavement leave, through funeral rituals, through the empathy of others – grief can follow a path of integration. When loss is invalidated – minimised, silenced, stigmatised – grief becomes 'hidden', and suffering migrates into the body or transforms into self-destructive behaviours.

A new paradigm of suffering

In the final chapter of this book, we propose a paradigm shift in the understanding and approach to human suffering. This new paradigm has four dimensions.

From patient to person – a critique of the classical medical model, which reduces the person to a diagnosis and a set of symptoms. To see the person

behind the symptom means to be curious about the patient's life, to respect their narrative, to meet them as a subject, not as an object of intervention.

From symptom to narrative – constructing a story that integrates pain, rather than excluding it. Narrative does not heal by magic – it heals through integration. When a traumatic experience is transformed into a coherent narrative, it ceases to be a persecutory presence and becomes an integrated part of personal history.

From cause to meaning – moving from the question 'why did this happen?' to the question 'what does this experience mean for me?' In many cases, there is no satisfactory answer to the question 'why'. The question of meaning is different – it does not seek a cause in the past, but a meaning in the present and future.

From treatment to accompaniment – accompaniment as an alternative to the treatment model. To accompany someone does not mean to lead them, to direct them, to tell them what to do. It means to walk alongside, at their pace, on their territory. It means to be present, to validate, to offer tools when they are requested, but also to respect silence and the need to be alone.

How to use this book

This book can be read in several ways, depending on your needs and interests.

If you are a clinician (psychologist, physician, social worker, counsellor), we recommend starting with Part 1 for the theoretical framework, then moving to Part 3 for practical tools (the 'Reclaiming the Body' protocol, couples therapy), and using Part 2 as a source of clinical illustrations for difficult cases.

If you are a researcher, we recommend starting with Chapter 2 (epistemology of pain) and Chapter 10 (research methods), which provide the methodological framework, then exploring the chapters relevant to

your area of interest – neuroendocrinology (Chapters 3, 4), infertility (Chapter 8), somatisation (Chapter 9).

If you are a policymaker or public health professional, we recommend starting with Chapter 13 (the politics of disenfranchised pain) and Chapter 14 (intercultural study), which provide analysis of the Romanian context and reform proposals.

If you are a bereaved parent or a person in suffering, we recommend starting with Chapters 1 (pet grief) and 5/7 (grief in fathers) or Chapter 8 (infertility), which offer an understanding of your own suffering and a language to name it. Chapter 15 (the new paradigm) offers informed consolation and a vision for healing.

An invitation

This book is not an instruction manual. There are no instructions for pain. It is, rather, an invitation – an invitation to look at suffering differently, to listen to it rather than eliminate it, to accompany it rather than treat it, to understand it rather than reduce it.

It is also an invitation to act. Beyond the consulting room, beyond the scientific article, beyond this book – there is a world that invalidates pain, that leaves people to suffer alone, that transforms normal grief into pathological suffering through silence and neglect. This world can be changed. And this change begins with each of us – clinician, researcher, citizen – who choose no longer to be silent, no longer to look away, no longer to accept as normal what is, in fact, a form of structural violence.

A less cruel society for the bereaved is possible. A less ethnocentric psychology of grief is possible. A new paradigm of suffering is possible.

Let us build it together.

Laura Mihaela Tihan and Eusebiu Jean Tihan
Bucharest, 2026

Part 1

The Theoretical and Personal (Intimate) Foundation

There are moments in a psychologist's life when the boundary between the one who listens and the one who suffers becomes as thin as a sheet of paper. Sometimes, that sheet tears. This is the case with the first chapters of this work — for they do not begin with an anonymized clinical case, but with a personal, profound loss that refused to remain locked in the drawer of "private experiences." Chapter 1 bears an unusual title for an academic work — *"What is the name of the dog who is no longer with you but lives in your heart forever?"* — and explores pet bereavement from the perspectives of clinical psychology, psychoanalysis, and anthropology. It is a chapter about attachment, about the names we receive after death, about the rituals that transform loss into continuing presence. It is, at the same time, a case study (of a Siberian Husky named Yuki) and a mise-en-abîme of the author's position — a clinical psychologist who becomes, for a moment, the patient of his own instruments.

Why does a work about perinatal grief and infertility begin with the story of a dog? Because grief knows no hierarchy. The loss of a companion animal can be, for some, more painful than the loss of distant relatives — and yet it is the least socially recognized, the most disenfranchised of griefs. Understanding the structure of this invisible grief is the key to understanding all the other forms of loss analyzed in this work.

Chapter 2 radically changes register, offering an archaeology of the epistemology of pain — from Hippocrates' humors to 21st-century biomarkers. It is a necessary chapter, because to understand how grief comes to be "embodied" in elevated prolactin, chronic cortisol, inflammation, we must first understand how we, as a medical civilization,

came to separate mind from body — and how we are now trying to reunite them. The chapter analyzes the crucial moment of the Cartesian rupture, its consequences for psychosomatic medicine, and the revival brought by the discovery of biomarkers (cortisol, prolactin, IL-6, TNF-α) that make visible what was invisible.

Chapter 3 enters the neuroendocrine core of attachment, presenting what the author calls the "relentless triad" — cortisol (stress), oxytocin (bonding), and prolactin (protective withdrawal). The complex interactions among these three hormones are analyzed, both in conditions of secure attachment and in conditions of loss and separation. The chapter introduces an original model: functional prolactin syndrome as the product of chronic anxious attachment, in which the "protective withdrawal" system remains activated even after the danger has passed.

Chapter 4 focuses exclusively on prolactin — the forgotten hormone of psychological suffering, eclipsed by cortisol in the specialist literature. It analyzes the psychological profile associated with functional hyperprolactinemia (hyper-responsibility, diffuse boundaries, inhibition of aggressivity), the interferences between thyroid pathology and prolactin, couple dynamics in the context of prolactin-induced decreased libido, as well as specific psychotherapeutic interventions (psychodrama, couple therapy, sensate focus technique).

Chapter 5 (which, in the summary of Part I, appears as an incipient version of what will become Chapter 7 in Part II) outlines the specificity of perinatal grief in fathers, anticipating the distinction between "silent presence" and "invalidated absence" that will be developed later.

Together, these five chapters build the theoretical foundation of the entire work: an epistemology of pain that refuses both Cartesian dualism and biological reductionism; a neuroendocrinology of attachment showing that loss is written in hormones; and a clinical approach to grief that knows how to listen to both word and silence, both weeping and chronic pain, both elevated prolactin and unseen shame.

What unites these chapters is the dual perspective — that of the clinician who observes and that of the human being who suffers. Rare is the academic work that begins with the death of a dog and reaches the neuroendocrine convolutions of perinatal grief. This rarity is, we believe, a virtue, not a flaw. Because suffering is not disciplinary — it is simply suffering. And the instruments with which we approach it must be as integrated as it is.

Chapter 1
What is the Name of the Dog Who is No Longer With You but Lives in Your Heart Forever?

A Narrative-Explanatory Analysis of Pet Bereavement from the Perspectives of Clinical Psychology, Psychoanalysis, and Psychological Anthropology

Abstract

The loss of a dog is not merely the loss of a pet, but the parting from a family member who has given us unconditional love. This chapter integrates theoretical perspectives from attachment psychology, psychoanalysis, and psychological anthropology with the personal experience of the authors, both clinical psychologists, who have experienced the loss of their own dog, Maya, a 14-year-and-6-month-old female Husky. The chapter explores the theoretical foundations of human-animal attachment, the psychological mechanisms of socially unacknowledged grief, and effective therapeutic strategies. Concepts such as disenfranchised grief, continuing bonds, guilt associated with medical decisions, and the importance of rituals are analysed. The conclusions emphasize the need for scientific and social recognition of this form of grief and the development of tailored psychological interventions. The answer to the question in the title is not a single name, but a plurality of names that reflect a plurality of bonds: ultimately, the dog that lives in your heart forever is called the presence of love that refuses to become absence.

Keywords: pet bereavement, human-animal attachment, disenfranchised grief, guilt, continuing bonds, mourning rituals, clinical psychology

1. Introduction

For Maya, our beautiful and noble Husky friend who left us at the venerable age of 14 years and 6 months, her name deserves to be spoken with respect and gratitude. The same goes for your little companion animal.

We write these lines not only as psychologists, but as owners who held their loyal friend in our arms in her final moments. Maya died hearing our voices and feeling our scent. Despite the brutal diagnosis — heart attack — the fact that she passed away peacefully suggests that our presence was the most effective anesthetic against fear. 14 and a half years is a long and fulfilled life for the Husky breed.

What is the name, I wonder, of the dog who is no longer with you but lives in your heart forever? This question followed us every morning after Maya's departure. It is a seemingly simple question. A child could ask it. But, as psychologists, we have learned that simple questions are often the hardest. Because they do not ask for a bookish answer. They ask for a confession.

In our culture, to give someone a name is an act of power and love. We name what we love. And when the loved one dies, their name becomes a relic, an invocation, a wound and a balm at the same time. But Maya is no more. And yet, she is. She is in the river stone in the garden, on which we wrote only this: MAYA — 14.6 Years of Pure Love. She is in the rustle of the oak tree planted in her memory.

The loss of a pet triggers real, deep pain, and, unfortunately, sometimes underestimated by those around us. It is essential to understand that what we feel is valid and that we have the right to grieve for a friend who was by our side every day [1]. In contemporary society, pets have acquired an unprecedented status within the human family. Studies show that, for most owners, animals are no longer simple "tools" or "property," but become family members, life partners, sources of emotional support, and,

for many, veritable existential anchors [2]. Recent data indicate that approximately 30% of pet owners experience intense grief following the loss of their non-human companion [3].

However, the pain associated with the loss of an animal is frequently minimized, ignored, or even pathologized by the social environment and, sometimes, by mental health professionals [4]. This phenomenon, termed in the international literature "disenfranchised grief," refers to those situations in which the loss suffered is not socially recognized, and the right to grieve is contested [5]. In the Romanian language, we could translate this concept as "socially unrecognized grief" or "disallowed grief," terms that capture the essence of the phenomenon: the pain exists, but society refuses to validate it.

As specialists, we know that grief is not treated, it is lived. However, in our case, several specific elements emerged. The trauma of powerlessness: the refusal of veterinary centers to intervene created a barrier in the acceptance process, leaving room for anger. It is important to process the fact that survival in the case of a heart attack at that age was, medically speaking, almost impossible, regardless of the promptness of the rescue. Role transfer: at that moment we were not the therapists, we were the ones who needed validation. All we could do was allow ourselves, to give ourselves permission to be vulnerable, without analyzing our processes through a clinical lens. The void of routine: after 14 years, the rhythm of our lives was dictated by Maya's needs. This void of care is the hardest to manage in the first weeks... even months.

The fact that we are psychologists by profession adds a complex dimension to this loss. We know all the mechanisms of grief in theory. We have read about Kübler-Ross's stages, about Worden's tasks, about complicated grief, about anticipatory grief. And yet, in the face of this loss, we are first and foremost owners who loved our life partner deeply for nearly 15 years. This duality — the specialist and the grieving person — is, in itself, a psychological phenomenon worthy of analysis. On the one hand, our knowledge helped us not to panic, not to pathologize normal

grief reactions. On the other hand, this knowledge became, in the first days, an instrument of self-invalidation. We told ourselves: we know that grief is not linear, we know that anger is normal, we know that acceptance comes in waves — so why does it hurt so much? Why can't we apply what we preach?

We thus discovered a particular form of disenfranchised grief: the grief of the psychologist who feels obliged to be resilient to pain. Our colleagues, perhaps well-intentioned, told us: "You know how to handle this." But no, we didn't know. Or, more precisely, we knew rationally, but we felt like any other person.

Because it is not only an emotional pain. It is a pain embedded in muscles, in habits, in reflexes. Every time we walked through the door, we expected to see her coming towards us, her tail spinning like a propeller. Every time we ate something, we instinctively looked at her, to stop her from begging. And each time, her absence hit us like a new blow. The specialist literature calls this phenomenon "the anticipated pain of absence" — a concept introduced by Attig in How We Grieve, where he argues that grief is not only an emotional state, but a reorganization of actions [8]. We must learn again to live in a world where our daily gestures no longer have the same recipient.

In the social sciences, there is an old debate: do we start with theory or with observation? Do we start with the hypothesis or with the question? We choose to start with the question. And not just any question, but the one that kept us awake at night: what is the name of the dog who is no longer with you but lives in your heart forever? This question is, in itself, a gateway to multiple layers of meaning. The linguistic layer: what does a name do when its bearer no longer exists physically? The psychoanalytic layer: how does the internalization of the lost object work? The anthropological layer: what naming rituals exist in other cultures for deceased animals? The applied psychological layer: how can we help grieving owners find a name for their pain, a name that is no longer just pain, but also meaning?

In what follows, we will try to answer this question. We will not offer a single answer. We will offer several. Because, as we learned from Maya, true answers are not always spoken. Sometimes, they are looks. Sometimes, they are silences. Sometimes, they are names we whisper at night, before falling asleep.

2. Theoretical Framework

2.1 Human-Animal Attachment and the Lessons of a Husky

Maya taught us that secure attachment does not mean clinginess. Secure attachment, as defined by John Bowlby, is the ability to use the attachment figure as a secure base from which to explore the world and as a safe haven to return to when frightened or tired [9]. Applied to the human-animal relationship, this theory reveals that companion animals can become authentic attachment figures, fulfilling the fundamental criteria proposed by researchers: the search for proximity, the secure base, and protest upon separation [10] [11]. Researchers emphasize that attachment patterns directed towards humans and those directed towards animals are comparable, suggesting that attachment theory can provide a useful framework for exploring how relationships with pets contribute to human psychological functioning [12].

Maya was, for us, exactly this secure base. Not because she followed us from room to room. Not because she cried when we left. But because, when we were at home, in her presence, the world became less threatening. She understood our speech, and with a simple glance she would surround us with silence and offer us answers. For a psychologist, this phenomenon is known as a supreme form of kinesthetic empathy and co-regulation, but for us, Laura and Eusebiu, it was simply Maya's "language."

Maya did not just listen to the speech; she felt it. She functioned as a safe space in which the tension of the day dissolved. Through her gaze, Maya conveyed to us that everything is, in essence, simple: "You are here,

I am here, the rest is noise." Often, in the face of life's great dilemmas, the answer does not come from logic, but from a state of silence. Maya offered us that state so that we could find the answers ourselves. She was the only one who did not ask us for solutions, but only for presence. She was the silent witness of all our feelings, without judging, offering that unconditional acceptance that Carl Rogers wrote about, but which only a dog can truly achieve [13] [1].

Attachment theory differentiates between secure and insecure attachment styles, the latter being subdivided into two orthogonal dimensions: attachment anxiety and attachment avoidance [14]. Regarding the loss of a pet, research shows that people with high attachment anxiety tend to experience more severe and prolonged grief [12]. People with high avoidance tend to minimize the importance of close relationships, suppress emotions, and avoid seeking or offering support [12].

Maya taught us that we can be free (like a Husky) and yet deeply attached. The lesson is about a love that does not possess, but accompanies. For 14 years, Maya did not live in the past or future. She anchored us in the "here and now" with every walk and every glance. She showed us that the deepest therapeutic processes do not need words. Her mere presence next to us was a form of emotional co-regulation. Her advanced age prepared us, with great difficulty indeed, but day by day, for the ultimate lesson of our profession: acceptance of loss as an integral part of life.

2.2 Disenfranchised Grief and the Psychologist's Vulnerability

The concept of "disenfranchised grief" was introduced by Kenneth Doka to describe those loss experiences that are not socially recognized, and the

[1] Rogers's necessary and sufficient conditions for therapeutic change (unconditional positive regard, empathy, and congruence) were formulated for the therapist-patient relationship, but many pet owners experience their animals as embodying these conditions in a way rarely found in human relationships [13].

right to grieve is contested or denied [5]. Doka identifies three main ways in which grief can be disenfranchised: the relationship is not recognized; the loss itself is not recognized; and the griever is not recognized.

In the case of pet loss, the main mechanism of disenfranchisement is the second: the loss itself is not recognized as significant enough to justify an intense or prolonged grief response. As the literature notes, the pet owner's friends and family members may consider pet grief unjustified, leaving owners feeling unrecognized and unsupported [3]. A study conducted on 160 Chinese young adults who experienced pet loss found that disenfranchised grief was a significant predictor of grief severity, especially in the context of heightened rumination [3].

Disenfranchised grief has significant psychological consequences, which can complicate and prolong the natural healing process. Research shows that this type of grief limits owners' ability to express their pain, exacerbates social isolation, hinders grief resolution, and increases levels of depression and anxiety [3] [15].

External disenfranchisement refers to the lack of recognition and support from the social environment. This can take the form of minimizing remarks ("it was just a dog, you can get another one"), lack of permission to take bereavement leave from work, or the absence of socially validated rituals for this type of loss[2]. In our case, as psychologists, we experienced this disenfranchisement in a particular form: even in the professional environment, there is often an expectation that a psychologist "knows how to handle" pain, which can lead to the invalidation of personal suffering.

Internal disenfranchisement (self-disenfranchisement) refers to the process by which the individual themselves suppresses or invalidates

[2] In many workplaces, employees are granted bereavement leave for the loss of a human family member, but not for the loss of a companion animal. This institutional lack of recognition reinforces the message that pet loss is not a "real" loss worthy of grief [17].

their own pain. This phenomenon is described by researchers as "suppression and disallowance of hurting" [16]. Self-disenfranchisement can be triggered by the internalization of social norms that minimize the loss or by personal beliefs such as "I shouldn't grieve so much for an animal." In our case, as psychologists, self-disenfranchisement took the form of a specific internal dialogue: we know all the mechanisms of grief in theory, but in the face of this loss, we are first and foremost owners who loved our life partner deeply.

Our experience as grieving psychologists highlights a particular form of vulnerability to disenfranchised grief. On the one hand, theoretical knowledge about the mechanisms of grief can create the expectation (both from others and self-imposed) that we should "cope better" or "process more efficiently" the loss. On the other hand, this knowledge can become an instrument of self-invalidation: the tendency to analyze our processes through a clinical lens can hinder the authentic experience of pain. This dilemma is recognized in the specialist literature as a form of "professional barrier to authentic grief" [18]. Mental health professionals are often perceived (and perceive themselves) as immune to the suffering they treat, which can lead to a denial of their own emotional needs and an increased risk of burnout and complicated grief.

In our case, we recognized this dynamic and made a conscious effort to allow ourselves to be vulnerable, without analyzing our processes through a clinical lens. This permission to be "just" grieving owners, not also psychologists analyzing their own grief, was essential for healthy processing of the loss.

2.3 Continuing Bonds: Between Pathology and Therapeutic Resource

The concept of "continuing bonds" has revolutionized the understanding of grief in recent decades. Unlike the traditional Freudian model, which considered that grief resolution involves "decathexis" (withdrawal of investment) from the internal representation of the lost person, the

continuing bonds model argues that maintaining a symbolic bond with the deceased can be adaptive and healthy [19].[3]

In the case of pet bereavement, continuing bonds manifest through behaviors such as: keeping the animal's objects (collar, toys), viewing photographs, visiting the burial site, talking about the animal, or even the sensation of its presence [12]. These behaviors are not signs of an inability to "let go," but normal and often beneficial ways of integrating the loss into continuing life. Recent research shows that pet owners who engage in activities reflecting continuing bonds with their deceased companion may experience clinical benefits, including less severe grief than those who do not [12] [20].

One of the most relevant aspects of recent research is the discovery of the moderating effect of continuing bonds on the relationship between attachment styles and grief severity. Researchers have found that continuing bonds partially moderates the relationship between attachment anxiety and grief [12]. More precisely, for people with high attachment anxiety, continuing bonds can amplify or reduce grief depending on how it is used. When continuing bonds takes the form of anxious rumination ("what could I have done differently?", "how could I have saved him/her?"), it can maintain and exacerbate suffering. In contrast, when continuing bonds takes the form of warm commemoration and symbolic integration ("what did this relationship offer me?", "how did this love change me?"), it can facilitate healing.

In our case, continuing bonds manifested in multiple ways, which we consciously integrated as part of the therapeutic process. We kept symbolic objects (Maya's collar, photographs) placed in a memory corner — a sacred space for remembrance, without allowing the objects to become triggers for painful rumination. We created commemorative

[3] The continuing bonds model was developed primarily by Klass, Silverman, and Nickman [19], based on studies of bereaved parents, and has since been applied to various types of loss, including pet loss.