

Dreams and the Reconstruction of Infant Trauma

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Abstract: Based on the psychoanalytic discoveries of Bernard Bail, M.D., this paper demonstrates that the earliest experiences of life, particularly the earliest traumatic experiences, can be retained in the unconscious mind of the infant and then lived out throughout the course of life in the form of behavior, symptoms, and characterological manifestations. The paper brings to bear research in child psychiatry, developmental psychology, neurobiology, and psychoanalytic infant observation. Three detailed clinical vignettes are presented using Bail's method of dream analysis to illustrate how even pre- and neonatal experiences can be accessed in the psychotherapeutic setting. The work illustrates the enduring effects of earliest trauma and represents a contribution to the study of primitive states of mind.

Zusammenfassung: *Träume und die Rekonstruktion des frühen Traumas.* Aufbauend auf den psychoanalytischen Entdeckungen von Bernard Bail zeigt dieser Artikel, daß die frühesten Erfahrungen des Lebens, insbesondere die frühesten traumatischen Erfahrungen, im Unbewußten des Kindes bewahrt werden und dann im Laufe des Lebens in Verhaltensweisen, Symptomen und charakterlichen Eigenheiten ausgelebt werden. Der Artikel zieht zur Unterstützung dieser Aussage Forschungen aus der Kinderpsychiatrie, Entwicklungspsychologie, Neurobiologie und der psychoanalytischen Kinderbeobachtung heran. Drei klinische Vignetten, in denen Bails Methode der Traumanalyse verwendet wird, werden vorgestellt, um zu zeigen, wie sogar vorgeburtliche und frühe nachgeburtliche Erfahrungen im psychotherapeutischen Setting zugänglich sein können. Die Arbeit zeigt die andauernden Auswirkungen frühester Traumatisierung und stellt einen Beitrag zur Untersuchung anfänglicher seelischer Zustände dar.

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We cannot take the newborn child as a tabula rasa but must consider the possibility that emotional experiences, their symbolic representation in dream-thought, and their impact on the structuring of the personality, may commence in utero. . . . Similarly the impact of interfer-

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ences such as prematurity, incubation, early separation, failures of breast feeding, physical illness in mother or baby reveal themselves in character development as unmistakably as the “shakes” in a piece of timber mark early periods of drought. (Meltzer 1988, pp. 8, 25)

How Do the Earliest Experiences of Life Etch Their Mark Upon the Human Character?

Perhaps we would have the best opportunity to investigate this question by focusing our attention upon the effects of trauma during birth and infancy¹, since traumatic experiences, either physical or emotional, reveal themselves more distinctly than “average expectable experiences.” Are there imprints or memories for trauma? How are they stored in the infant and later acted upon? How do we reconstruct them as such at a later point in time? Can the emotional meaning of these events to the infant also be reconstructed?

Until the advent of recent infant research, it had generally been assumed that the infant had no memory to speak of and that the earliest phase of life was characterized by a “vague and amorphous” state of mind (Bernstein and Blacher 1967; Freud 1969; Rubinfine 1981; Dowling 1982; Fajardo 1987; Arlow 1991). Thus it was thought that discrete experience, even when traumatic in nature, could not be stored and retained as such by the infant. Reconstructing a veridical account of the infant’s experience in the course of psychotherapeutic treatment was thought to be impossible (e.g., Kris 1956; Freud 1969; Arlow 1991).

However, Phyllis Greenacre, an American psychoanalyst, wrote as early as 1941 of the possibility of reconstructing events from the beginning of life. She stated:

As patients speak of their own birth injuries, their earliest illnesses, accidents, the attitudes of their mothers toward and during pregnancy, I reconstruct for them the possible effects of such experiences on a young child. . . . It is interesting that one can in the course of such interpretation pretty well reconstruct what has been the specific experience of the given patient. He does not recover clear memories or confirmatory evidence which he can convert into words, but he reacts with wincing, increase of tension, or the appearance of confirmatory somatic symptoms when the old sensitive areas are touched, even when this has to do with events of the very earliest weeks and months of life. (p. 67)

Similarly, Donald Winnicott, a British pediatrician and psychoanalyst, wrote in 1949, “I do find in my analytic . . . work that there is evidence that the personal birth experience is significant and is held as memory material” (pp. 176–177).

Recent studies in child psychiatry, experimental psychology, neurobiology, and psychoanalytic infant observation support the notion that an early memory system exists, and that therefore a later reconstruction of infantile events and the infant’s experience of such events may be possible.

From child psychiatry, Lenore Terr, M.D. (1988, 1990, 1991), University of California Medical Center, San Francisco, studied verbal and behavioral memories of traumatized children under the age of 5, comparing the memories with documentation of the same events. She found that at age 2 1/2 to 3, most children retain and later retrieve some type of verbal memory of trauma. By this

¹ Infancy is defined here as birth to 3 years.

age, children can say in words what has happened to them. But her most significant finding was what happens with trauma that is inflicted from birth to 2 years, a time when no verbal memory exists. Traumatized children from this group showed behavioral memory of their traumas. They reenacted in play or in other behaviors at least a part of their traumatic experiences. For example, a child who had been sexually abused from birth to 6 months in a day care setting played out the exact details of her abuse (as verified in photographs confiscated by the police) when she was interviewed at 2 years 11 months. Terr (1988) states, "What is striking is how literal their behavioral memory is, how early it comes into operation, how accurate the details are" (p. 98), and how long it continues.

To address the issue of "how long it continues," George Engel and his research group (Engel et al. 1985) conducted a 30-year longitudinal study of Monica, a woman who had been born with congenital atresia of the esophagus. For the first 2 years of her life, her sole method of feeding was lying flat on her back with a feeding tube inserted into her stomach. No one at any time physically held or made contact with her during feeding. As a child, Monica fed her dolls in this same lying flat/no contact position. Thirty years later, she fed each of her infant girls in the identical manner and could not seem to do otherwise (she said her arms were too tired or the babies were too heavy). This position was "natural" for her. Nothing else seemed comfortable. This position was natural despite, as a young child, seeing her four younger siblings being fed in an arms-folded position and assisting at such feedings and despite the encouragement of her now adult siblings and husband to "hold the babies." As the years passed, and most astonishing to the Engel's research team, Monica's young girls began feeding their dolls in this position as well. The trauma had somatically and unconsciously passed down through to the next generation.

From experimental psychology, Eve Perris, Ph.D. and her research group (Perris et al. 1990), University of Massachusetts, put twenty-four 6 $\frac{1}{2}$ -month-old infants into a unique laboratory setting in which they had to reach for a sounding rattle under two conditions: first when the room was lighted and second when the room was suddenly darkened. The experiment was presented to the infants only one time. Two and one-half years later these same children were reintroduced to the identical setting and task, side by side with a control group (children of the same age who did not have the early experience). The experienced children reached and grasped significantly more than the control group children. Furthermore, the experienced children were four times better able than the control group children to withstand the slightly scary experience of being plunged from the light into the dark. Perris et al. (1990) conclude:

Even if infant encoding processes were limited and the resultant memory traces fragile, forgetting was not complete. . . . An early memory system is functional in infancy and can, at least by 6 months of age, mediate long-term memory. . . . Two years of physical, neurological and cognitive changes do not prohibit retrieval based on the infant memory process. (pp. 1805–1806)²

² Perris and her group demonstrated a memory system operating from 6 months of age. Shortly after the publication of Share (1994), Andrew Meltzoff and Keith Moore (1994) introduced evidence that babies only 6 weeks old will remember and spontaneously imitate the facial expressions of a person who has been out of sight for 24 hours. Their experi-

Evidence for the physiological underpinnings of Terr's, Engel's, and Perris's findings comes from recent research in neurobiology. Joseph LeDoux, Ph.D. (LeDoux 1989; LeDoux et al. 1989), University of New York, Center for Neural Sciences, demonstrated through his animal fear-extinction experiments that the amygdala, rather than the hippocampus, is the center of primitive emotional reactions and that the amygdala operates independent of, and prior to, thought, triggering an emotional reaction before the thinking brain can fully process the nerve signal (somewhat analogous to Wilfred Bion's, 1962, notion that thoughts occur before thinking). LeDoux's experimental studies demonstrated the indelibility of subcortical emotional learning and suggest the possibility that precognitive emotions may be registered in earliest infancy and persist through time. This may occur because the amygdala is more fully formed during the first year of life than the hippocampus (necessary for cognitively oriented processes). As a consequence, emotional memories, fears, and resentments from the beginning of life may be formed, stored, and then acted upon throughout life in the form of symptoms, dreams, transference manifestations, and so on (Goleman 1989, 1994; Blakeslee 1994).³

And finally, going *Backwards in Time* (1986), Alessandra Piontelli, M.D. (1987, 1989), an Italian psychoanalyst from Milan, studied the possibility that mental life, ego functioning, and awareness already exist in the fetus and the consequent bearing of this on the mental functioning of the baby. She observed individual and twin fetuses monthly, via ultrasound, beginning in the fourth month of pregnancy. She followed them with 2 years of weekly infant observation. She found early markers of individual temperament and behavior beginning in the womb and continuing in the same direction during infancy. For example, a very sensual fetus who continually licked and stroked the placenta and the umbilical cord, licked and stroked everything in sight during her first 2 years of postnatal life.

Further evidence for a link between an individual's mental functioning and prenatal experience has been provided by Piontelli (1988), who analyzed a 2-year-old psychotic child. The patient had stopped moving in the womb at 5 months and was born with the umbilical cord doubled tightly around her neck. In addition, this child underwent painful medical procedures during hospitalization in her first month of life. She seemed to live out in all her actions and autistic "play" the memories of her past entangled life inside the womb. She wore a heavy double-knotted chain around her neck, refusing to part with it. She continually pressed an object

ments demonstrate not just recognition memory but actual "recall" memory, which was not thought to be possible until 18 months according to Piaget and 9 months according to more contemporary memory research. Meltzoff and Moore found that babies will imitate the facial gestures they remembered from the previous visit of a particular individual, as if to check out and identify who they were seeing: "Are you this person who looked and moved like this?"

³ Since the publication of Share (1994), Larry Cahill and colleagues (Cahill et al. 1994), Center for Neurobiology of Learning and Memory, University of California, Irvine, demonstrated through adult affectively charged learning experiments that emotionally charged experiences seem to be "imprinted" in memory whereas ordinary experiences are not, and that the amygdala appears to be the key brain site where adrenergic hormones (adrenaline and noradrenaline) lay down these experiences. Again, the emotionally charged experiences bypass the hippocampus.

horizontally across her navel. She played with the cord and curtain in Piontelli's office, wrapping herself up like a mummy, excluding the rest of the world, and by these various means recreating her past life inside the womb.

With the evidence from these studies, what of adults who may have undergone early and/or never consciously remembered trauma? How would we identify such experiences? How would we recognize their effects?

Over the years, the adult patients I have worked with have experienced emotional and at times physical trauma in infancy. Some of these traumas have gone as far back as birth. Often dreams of their early traumas emerged at the time of the person's birthday or at the time of some anticipated metaphorical birth, such as a new career opportunity, or a marriage, or a "psychological birth" in the treatment itself. The impact of such trauma on the development of the person's character, and the very detailed and specific ways in which it remains alive in the personality and is enacted in the present can be quite profound. As will be described, the psychoanalytic understanding of infant trauma and its elaboration in the unconscious developed by Los Angeles psychoanalyst Bernard Bail, M.D. (1993, personal communication) illuminates how these processes can occur. Birth and infant experiences and the emotional meaning of these experiences appear to be stored in the unconscious from the beginning of life and later symbolized and thus utilized for dream-thought and retrieved in dreams much later in life in the therapeutic setting. Dreams may reveal in symbolic form the memories of actual traumatic events as well as a metaphorical expression of the meaning of these events to the individual. Through an understanding of such material, we as psychotherapists and psychoanalysts have an important opportunity to "emotionally touch" a person in a very profound way – to "bring alive" for him or her how earliest experiences have shaped the very essence of his or her personality and how they affect the therapeutic interaction at a given moment in time.

According to REM-sleep research, REM-state dreaming has been detected from 6 months in utero (Roffwarg et al. 1966). Therefore, it is possible that even intrauterine life is included in this unconscious/dream storage. The primitive unconscious knowings of the infant (and possibly the fetus), or what Christopher Bollas (1987) calls "the unthought known," may be stored initially in the infant's dream in a primitive sensorial form. It then remains available for transformation – a "retranscription" of sorts – over time and, as development proceeds, into contemporary pictorial symbols characteristic of dreams in adult life.⁴

Freud (1900) postulated that the primary function of the dream is to provide discharge or gratification for impulses or wishes infantile in nature and unacceptable to the conscious mind. Contemporary dream theorists suggest a much broader scope for the dream than the drive-discharge function. They suggest that the dream can illuminate one's internal world and one's self-representation (e.g.,

⁴ Renewed interest in the dream and its possible connection to infant memory and learning has recently been generated as a result of the work of Avi Karni and his colleagues (Karni et al. 1994) at the Weizman Institute in Israel. Karni's work demonstrates that REM sleep improves skills learned by repetition, or what is called "procedural memory." Procedural memory is thought to be a prominent type of memory in infancy. Consolidation or strengthening of procedural knowledge and memory appears to occur in REM states (the "Karni effect"). REM deprivation also deprives one of procedural learning (Baromaga 1994).

Fairbairn 1952; Kohut 1971; Rycroft 1979; Atwood and Stolorow 1984; Mancina 1988); it can portray real and traumatic experience (e.g. Ferenczi 1931; Sharpe 1937; Garma 1946); and it can explicate the range of efforts made by the individual to solve essential human dilemmas in the struggle to live a life (e.g., Tauber and Green 1959; Weiss 1964; Greenberg and Pearlman 1975).

Bernard Bail, who, over the past 40 years, pioneered the particular method of dream analysis and its capacity to reach infancy and the enduring impact of infantile trauma that I present today, puts forth the idea that the dream reveals “the essential unconscious situation” to be addressed in any given analytic hour.

The dream properly interpreted is the truth of the patient’s life. This truth is immediately apprehended emotionally, which lends great conviction to the interpretation and leads to a deepening of the personality. The main function of the dream is to bring the possibility of the truth to the patient, much as the compass tells the navigator whether the plane is on course. Living the truth of oneself is the essential goal of psychoanalysis. Fundamentally this is a moral view. (Bail 1996, personal communication)

The dream, Bail states, brings to us that which must be known at the current moment in treatment for the patient to “grow his mind” and to “move forward in life.” Bail notes, however: “Before one can ‘grow’ the mind, it is imperative to make sure that the patient *has* a mind, a statement that on the face of it would seem commonplace to all psychoanalysts yet requires significant amplification not possible here. Actually, a great deal of work has to be done to establish a mind. If there is no real mind, a development will ensue that is entirely false” (Bail 1986, personal communication).

Clinical Presentation

This presentation represents one fundamental segment of the unconscious mind: that of earliest infancy as it is captured in the dream. According to Bail’s analytic theory, the universe of the unconscious mind addresses the entire range of the human phenomenon: impulses, fantasies, the various stages of development, and actual experience and memories. All are available to us through the dream. Actual experience can be distinguished from fantasy in the course of analytic work, according to Bail. The clinical examples in this paper demonstrate the emergence in dreams of the infant’s earliest physical happenings as well as the infant’s emotional experience of and fantasies about such happenings.

I will now present three examples from my book. Of the eight individuals presented in the book, one did not know there had been an early trauma until it emerged in a dream during treatment and her mother subsequently verified it. The others were told, often as children, of the “facts” of their experience. For these individuals, the dream seemed to elucidate the most significant emotional meaning of their trauma, that is, how the trauma affected their life-long struggles to live in the world and to be born psychologically.

The specific early material represented in these examples was ascertained utilizing Bail’s method of dream analysis. This method is distinctive in its focus on the importance of gathering all possible associations to the dream and in the fine detail with which these associations are treated. A synthesis of the entire dream and its various elements is attempted.

There are no preconceived meanings or symbols, but each word, each dream element, each association is taken as new and fresh as if one knew nothing at all, as if one were a newborn baby. These disparate associations are then considered in relation to each other, and seem to reveal a coherent story that the patient's unconscious is trying to tell. (Bail 1993, personal communication)

The specificity of Bail's dream interpretation method has enabled him to verify through his analytic work with all of his analysands the universality of infantile mental trauma and the consequences of such trauma for all the rest of one's life.

Because the evidence is incontrovertible that initial infantile traumatic events become transfixed in the personality despite the outward dressing, the masks that the personality assumes throughout adult life unto death itself. None of us is exempt from this phenomenon; all of us bear its mark in some form. (Bail 1996, personal communication)

In the examples presented, the traumas of birth and infancy unearthed during the process of analyzing dreams were linked to behavior, symptoms, character, and transference manifestations. What became evident in these analytic hours was that experience of the distant past remained powerfully alive in the immediate present.

Clinical Examples

Clinical Example No. 1

Mr. F. was a 19-year-old young man who came to treatment because he could not find any interests, goals, or direction in life. He described himself as suffering from an underlying depression and malaise. He had completed high school with great effort, though he was very bright. He began college but dropped out shortly afterwards, finding the work too laborious. He took a manual labor job instead. He preferred to spend his time in his room, sleeping for long hours, watching TV, and eating. He was quite a handsome young man, and girls often called to extend invitations to various parties and events. He had little interest in these social activities and usually declined the invitations.

Mr. F. was the second of two children, with one older sister. His parents had a difficult marriage and divorced during his early teens. Mr. F. felt abandoned by his father, whom he rarely saw. His mother was now working two jobs to support the family and to pay for therapy for herself and her two children. It seemed understandable that this young man would be depressed.

In the initial months of treatment, we focused on the patient's feelings and conflicts related to his parents' divorce and his longing for his father's more active presence in his life. Within the first 6 months of treatment, the patient began feeling better. He had just started running track and had been taking a course at school. He had begun going out with some friends and completing daily chores, tasks that had always seemed overwhelmingly laborious to him in the past. In the session in which he reported these changes, he described the following dream:

I was parked in a parking lot garage. I tried to exit but found that the exit was still under construction and not complete. I went down the exit ramp anyway and smashed in the front end of my car in the fall. I was not permanently hurt but the car was dented. A man came up and said, "You're lucky you made it." I returned to school, and I noticed that when I looked down, my feet were bare and I was wearing white shorts and an undershirt. I was

told that my teacher was no longer competent and was being replaced by someone new. The new teacher was a very capable old family friend, Celia.

Mr. F. was puzzled by this dream and had difficulty thinking of any associations. The car was his current Volkswagen. He parked in a garage frequently. He could not associate to the incomplete ramp exit from which the car fell and the front end was smashed but he was not permanently hurt. He noted that he had one car accident but that his car had been hit on the side, not the front. He had never been in a front-end crash. He had no associations to the man saying that he was lucky he had made it, and he could not describe the man. He said that such a statement is something a person says to you if you made it through some disaster or some near-miss, life-threatening situation. No such thing had ever happened to him. He did have an association to the bare feet, white shorts, and undershirt. He spent a lot of time dressed that way at home when he was lounging, sleeping, or watching TV. He stated that from his many dealings with his teacher, she seemed to be a very kind and capable woman who would not be likely to be fired. He found the history course she taught interesting. She organized and managed all of the learning activities for his freshman class. He did not know what precipitated the firing in the dream. Celia, the woman who was taking over as teacher, was also a very capable person, a long-time friend of the family whom he had known all of his life. She had cared for him when he was a baby.

Like the patient, I was puzzled by this dream. Certainly the bare feet, white shorts, and undershirt and his lying in bed seemed to represent his infantile, regressed, "small car" self. The garage and his difficulty exiting certainly also seemed to stand for some aspect of the withdrawn, "inside" state of mind in which he lived. Metaphorically, coming out into life and developing as a young man presented some real danger. But what to make of the very specific imagery of the smashed front end of the car and someone saying, "You're lucky you made it"? A car often stands for the self in a dream. If the front end was smashed, then perhaps Mr. F. was making reference to a specific and concrete experience in his dream, something that had actually happened. It also seemed to refer to a time when he left some place, some "inside" place, before it was ready. When he did so, something specific happened to his head (the front end of the car). If he was lucky and made it, then the experience was a "close call" of some sort. His life might have been in danger. I thought the inside of the garage might be the inside of his mother's body (since he was clearly still living as a baby) and that something of her body (the construction of the ramp) was not complete, although there was no question that he was also incomplete – his development was not progressing normally.

Thus, I suggested, after attempting a more metaphorical understanding, that this dream might relate to his birth (about which I knew nothing at the time) because of the form of the dream and the very lack of his associations. I suggested that the lack of associations might indicate that he was describing an experience from a time when he would not have had any associations, that is, any other experiences to relate it to. I said that if this was his birth and a description of his beginnings, then perhaps he was saying that he went down the birth canal when it was under construction and not complete, that he had had a premature birth and was not ready to be born. The reference to the smashed front end of the car might mean that some damage occurred during the birth process. It might have been the

doctor or his parents saying how lucky he was to have made it. I said that I assumed that the bare feet, white shorts, and undershirt when he returned to school was a reference to him as a baby in diapers and shirt, but that I did not know the meaning in this context of the dream, if in fact this was indeed a dream regarding his birth.

The patient gasped and said, "Oh, this is amazing that my dream could so clearly depict the situation." He then told me that his mother had been Rh negative, and that she had miscarried after the birth of his older sibling. She had been told by her doctor that it was very unlikely she could carry through another pregnancy. Mr. F. was, in fact, born nearly 10 weeks prematurely. There was a difficult delivery. Apparently there were some significant forceps marks on his head but no permanent damage. He had spent a good deal of time in an incubator. His mother had been extremely ill during her pregnancy and delivery with complications from the Rh factor. She was unable to care for the baby for a considerable time. A nurse was hired to care for him when he went home and for several months following, while his mother recuperated. This woman became a friend of the family.

I told the patient that the teacher who was fired must be a woman who was part of his history, his warm and usually competent mother. She was replaced by the new "managing" and "organizing" nurse – the nurse he had known all his life who provided the organizing care he needed when his mother was so ill and unable to function for him as a mother. This reference to the new teacher/nurse also appeared to be a reference to me and to his treatment, which now seemed to be providing this managing, organizing experience.

I commented that what was striking about this dream was not just that it depicted his early experience so clearly, but why it had occurred at this particular time. After a long pause, the patient blurted out with a start, "It's the running track!" I asked what he meant. "It's the fact that I now have energy, that I am doing things, that I'm taking care of myself, and that I'm getting out in life. It's about the change!"

In the next session, Mr. F. came in saying that he had thought about the last dream all day and had asked his mother "a million questions" about her experience. (We see here the value of dreams in stimulating curiosity about the mind, in addition to a person's reclaiming his history.) His mother had told him more of what she could remember. Her labor had been approximately 36 hours long and had been induced because in another 72 hours the baby would have been poisoned by the Rh complications had they not delivered him. His mother told him that he was so tiny when he came home that his parents were afraid to touch or to hold him. Perhaps, I said, the dream was expressing his feelings then, and perhaps even his feelings now, that he needed a new nurse-manager who was not afraid and who would be able to care for and hold such a tiny infant with all its premature parts.

In this hour I speculated that perhaps in the dream of the previous session his returning to school barefoot and in diapers and shirt was saying that he had remained living in the state of mind of a 10-week premature baby. In that state of mind, life would simply have overwhelmed him. He could not have managed the ordinary tasks of life. Certainly school, chores, relating to friends, and so on would have been tremendously difficult. In such a state one could only think about the basic functions for survival: breathing, sleeping, eating, evacuating. Beginning to cry, Mr. F. responded that his favorite position was to lie in his bed curled up

in a fetal position, listening to TV, and eating crackers, and then going to sleep while watching his breathing. He had been preoccupied for as long as he could remember with watching his breathing: breathing in and breathing out. How does one know that one will take another breath? What insures that a breath will be taken? He said that at times he thought he could not stand to think about things for too long. I said, "How could an almost 2¹/₂-month premature infant stand to think? If it had to think, it could only know how difficult and precarious its life was." The patient agreed.

The patient gradually progressed over time. He began to be able to sustain interactions with people. He eventually returned to school part-time while retaining a part-time job. He began dating periodically and engaged in some school athletic activities. He spent progressively less time in his room in a regressed state. In the transference, I took up the contrast rather regularly between who I was when I seemed to understand his infant self (the care-taking nurse, Celia) and who I was when I did not (the Rh negative factor, a destructive force at best).

Of interest was the day residue for this dream. It appeared to have been precipitated by a psychological birth in the patient: a true change in his way of feeling and being, the beginnings of a move into a psychological life and a rudimentary self. The dream seemed to serve the purpose of recalling or reviewing for him where he had come from. He was not to forget how this all came about. I would consider this, then, a "change-of-state" dream.

Clinical Example No. 2

Ms. C. was a 31-year-old woman who was sent to me for therapy following the suicide of her mother. Her parents had divorced when she was 4 1/2 years old and her mother moved to another state, leaving the patient with the father. The patient visited her mother a number of times during her fourth year, but the visits became so traumatic that she did not resume them until she was 28 years old. At that time, the mother began indicating to the patient that she was going to kill herself. During one visit, the mother brought a display of lethal weapons (guns, rope, pills, knives) to her daughter and asked her to choose the weapon of her (the mother's) destruction. The mother did eventually kill herself by hanging, and my patient was in a state of posttraumatic stress following her death.

When I first saw Ms. C., shortly after her mother's suicide, she was married with two young children but was in the midst of divorce proceedings. She had been seen in treatment for only a couple of months when she had the following dream, a few days before going to court in the state where her husband lived in order to have the divorce finalized. On the day of the session, as I opened the door, she held up a bag of empty sandwich wrappings from her lunch and asked if she could throw them away in my garbage. She lay on the couch and reported the following dream:

I was taking a plane to the East Coast to go to the hearing for the divorce, just as I am planning to do in a couple of days. When I landed at the airport, I went immediately to the home of my cousin. She was having a party. There was a good deal of noise, but I could not hear specifically what people were saying, just the sounds of other voices. I decided to go out for a breath of fresh air. My husband was standing at the door. We looked at each other, and he asked me to go for a cup of coffee. We went to a restaurant and sat at a table, and each had a cup of black coffee. We looked at each other and sat in silence. We really

had nothing to say to each other. We just sat and stared, and drank the coffee. Following this, we went to court. It was really a very simple matter. I said I wanted a divorce, and they just stamped it with a stamp, saying the divorce was complete. Very easy. I then went over to the hospital where my children were born to get their immunization records. I got those records, and then I went back to the party. Only this time there was a great big board in the center of the living room. I took an eraser and erased all the things written on the board, and cleaned it up. Then the entire scene from the first part of the dream was repeated. I went outside for a breath of fresh air, there stood my husband, we went for coffee, stared at each other, had nothing to say, and then I took the plane and went home.

A summary of my questions to her and her responses and spontaneous associations follows. Bail's method of working closely with the details of the dream elements as well as a synthesis of these elements into an unconscious narrative is well illustrated in this particular example.

[Going back East]: I am going to the East in a couple of days for the divorce proceedings. I am nervous about it, but I think my husband will cooperate.

[Her cousin's house. Why did she pick her cousin's home to locate where she landed? Did she have any special relationship to her or to the home?]: She was my very closest friend at the time I lived in the East. We got together around our pregnancies. We took prenatal classes together when I had my first child, Lamaze and Taking Care of Baby. We read about and talked about our babies: what they would be like when they arrived; whether or not they could feel what we were feeling. She and I have remained in touch over the years, and I look forward to seeing her when I go back. She is a very decent person, and I always enjoyed her company.

[A party at her cousin's house; the people she couldn't make out]: She didn't have parties often; neither did we. I was often there for dinner. I'm not much of a party person, in fact. I don't like crowds much. It would be typical of me to go outside for a breath of air when in a room with a lot of people. I didn't recognize any of the people specifically.

[Her husband greeting her at the door]: The situation with my husband at the door was just as it is; we never had much to say to each other. We're there, but there's never been much communication. I don't like coffee. I never drink it. It's bitter. I don't think it's very good for you.

[Going to court to get a divorce; having the paper stamped]: I anticipate what the divorce proceedings will be like. I hope it is as straightforward as in the dream – whether it was the judge or a clerk. I couldn't really make out anyone distinctly. I only know the paper was stamped, as I imagine is done, indicating the divorce was granted. I hope this is how it happens.

[Going to the hospital to get her children's immunization records]: I do have to get my second son's immunization records because he is starting preschool. But the records are at the doctor's office, not at the hospital. My stay at the hospital for my children's births went well. There were no particular difficulties. Nothing comes to mind about this.

[The board in the living room]: The board, when I went back to the party, is the most interesting thing. It reminds me of the board where I keep track of all the residents and staff in the adolescent residential treatment center where I work – which room the residents are in, the times and locations of their activities, the staff shift changes, and so on. The board is filled every day, all the time. You know,

I've never had any hobbies or interests. My mother was a musician. She played the flute. My father is a biologist. So it was some surprise that I've always had trouble learning in school. All subjects were so difficult for me. But for some reason, I have this board memorized in detail. I know every location, every patient, every activity, and I keep track of them precisely, which is why I have done so well on this job.

[The eraser]: The eraser in the dream was what I use to erase the board at the end of the day. I don't know why I repeated the scene. There was my husband, there was the coffee, there was the staring, and the whole thing happened again.

Where to begin with this dream? It is long and involved. The majority of the patient's associations seemed to center on her impending divorce. Certainly this was her conscious concern over the last few days. So it seemed that the divorce was the day residue. If this was the case, then one part of the dream struck me as truly out of place: her landing at the home of her cousin, to whom her main associations involved experiences with pregnancies and prenatal issues. Why at the time of the divorce was she thinking unconsciously of prenatal classes and concerns with what went on in the womb? I thought of her husband, a man she described as "empty of nutrients" and uncommunicative. Whom could he stand for? Had I been providing her with very little, and was she trying to divorce me? I recalled how disturbing Ms. C.'s contacts with her mother were and how the mother made little effort to contact her daughter after the father stopped visitation. How does a mother let her daughter go so easily? Her mother was essentially uncommunicative for some 24 years. Perhaps the husband stood for the mother or, in her experience, the mother and husband were emotionally similar. Ms. C. was still in a profound state of shock regarding her mother's recent suicide, and it was still her fundamental preoccupation. I was unclear as to why she was going back to prenatal times in the dream. I felt, however, that we should start here, since this is where she started the dream. If I started where she landed, then maybe the rest of the very lengthy dream, which she described almost in the form of a story, would actually tell us the rest of her story. Then perhaps the sequence of what had happened to her, or the sequence of at least her emotional experiences, would become clear.

I thus took up the dream in the following way over the course of the hour (the interpretations are condensed here into a single narrative for purposes of presentation). I told her that I thought the key to understanding the dream began where she landed: the home of the cousin with whom she took prenatal classes. I felt that this probably located the situation, not so much in the current divorce, although this must certainly be involved, but rather at the time prior to or at her birth. I said that I did not know why she would be dreaming about her birth or her prenatal experiences at this time. (She also seemed unclear at this point as to why.)

I then speculated that the scene at the party, where she could hear the sounds but did not recognize any people, might be her mother's womb, that she was perhaps listening to the sounds from inside the womb. I said that I thought she was telling us a story of her birth and her experiences with her mother and what she attempted to do to cope with these experiences. It appeared that she attempted to go outside for a "breath of fresh air," meaning to get born, and was greeted by a mother who was simply uncommunicative. They only stared at each other, the mother having nothing to say to her. There was no cooing and loving breast milk, but only staring, with nothing to say – black coffee, bitter and empty of nutrients.

I said it appeared from this dream that when she became aware of the nature of the situation with her mother at birth, this empty experience – with no communication and only staring – she tried to get a divorce. In the dream, it was a very simple matter; she would just get the paper stamped and say, “That’s fine, this is not my mother,” thus denying the fact that as an infant she could not divorce herself from a mother who did not want her and had no way to communicate with her. When she realized, I said, that she could not get a divorce from her mother, she tried to get “immunized” from the experience. In the dream she went to the hospital to get the immunization records.

How does a baby who realizes she has a mother like this begin to immunize herself against such an experience? It appeared to me from what followed in the dream that the immunization did not work well, so the only way she was able to exist and preserve herself from the awareness of a mother who could not contact her was to erase her mind. The board in the living room represented her mind and everything that was on it, including her experiences with her mother. She felt she simply had to erase it. At one point in the hour I suggested that this might be connected to her learning difficulties in school, and her lack of hobbies and interests. Such activities meant she would have to preserve her mind, the experience with her mother, and so on.

In discussing the repeated breath of fresh air scene, I said I thought that the fact that it happened a second time could have two representations. First, she had gone back to see her mother for the second time when she was 28 years old, the emotional experience being identical to the first – nothing had changed. Second, she might feel that I would be like her mother and that she would have to erase (or already had erased) the treatment here, and my interpretations. She would like to throw away the experience with her mother, as she had asked when she came to the door whether she could dump her garbage into the garbage can in my office. She was worried that, instead of her being able to get rid of her experience with her mother, our attempt would be to understand it and she would have to erase this here too in order not to experience it again.

Ms. C. had a striking response to these interpretations. She said, “Oh my god, it was my birthday this week. I always get very depressed at the time of my birthday. I forgot for a moment.” (She had erased it.) “I never like to think about it because my mother told me that when I was born she thought I wasn’t her child because I was so ugly and didn’t look like her. She thought they had mixed up the records in the hospital and that I was somebody else’s baby. She told me she didn’t want me when she saw me.” I commented that perhaps she had wanted to check the records in the hospital in the dream in order to make sure she was actually the baby of this mother. She then began to recall occasions when her mother told her of her dislike for feeding and caring for her as a baby. She remembered how her mother had repeatedly said that as an infant, Ms. C. had interfered with or disrupted her mother’s life. Ms. C. continued with an outpouring of associations to her mother’s hatred of her.

When I spoke of her wish to erase all of these painful happenings, Ms. C. stated that the chemical solution used on the eraser to erase the blackboard was extremely powerful. One had to be careful not to get it on one’s hands because it would damage the skin.

Ms. C. began to make efforts toward more significant learning experiences during treatment. She eventually returned to school part time, having become interested in working with preschool children. The theme of erasing me and the interpretations was taken up throughout the treatment whenever painful material emerged that she wanted to forget or actually did forget.

Ms. C.'s marital situation was of interest. She did not divorce her husband. Over the course of many months of treatment, her husband became sufficiently differentiated from her mother that she began to see more clearly the caring side of him and his desire to continue the marriage and remain a father to their children. She began to feel more warmly toward him, particularly after her identification with the mother who had abandoned her was taken up. It appeared that Ms. C. identified with this mother, precipitously leaving a husband who stood for her own abandoned baby-self. She eventually returned to their home in the East and to her marriage. She entered therapy as well as marital counseling in her hometown.

Ms. C.'s dream reflects an infant's awareness, from the time of birth, of the emotional deprivation and emotional abuse of a mother who rejects and is unable to care for her. It is certainly a matter of debate, but I do not feel that this dream is a projection backward, that is, that the patient's current state of knowledge was imposed on her birth situation. Rather, I feel that the patient's ongoing experience with her mother, and her developing cognitive and perceptual capacities as she grew, provided the means to represent, to symbolize in a dream, that which was known emotionally from the very beginning of her life. Such an understanding is in line with the psychiatric research findings of Rima Laibow (1986) and Lenore Terr (1988) and the psychoanalytic investigations of Helen Schur (1966), Ann Bernstein and Richard Blacher (1967), Bernard Bail (1981), Michael Paul (1981), and Scott Dowling (1985): Primitive sensory experiences and early mental processes may be "reworked" into new, more mature forms as development proceeds. These forms help to organize emotional experience into verbal forms capable of symbolization. Thus, the capacity for symbolic representation in the dream work.

Also, I feel that this dream is a very important illustration of the "compromise of the mind" that can happen when trauma involves hostile maternal projections into the infant (Ferenczi 1932; Fairbairn 1952; Kahn 1964a,b). According to Bail (1993, personal communication), the baby, faced with significant pathological parental projections, may have to "leave his own mind" even from the very first moments of life. His mind *must* become that of his parents. The baby becomes identified with the parents and their pathology, thus meeting the parents' unconscious needs. In this way, the infant sustains a relationship upon which his very physical survival depends. Ms. C.'s dream suggests that she left her mind by erasing it from the time of her entrance into the world in order to mute awareness of a mother who did not want her to exist. She could not have her whole mind – her whole self – psychologically survive. A product of two intellectually gifted parents, she could not learn, develop emotionally, or grow mentally. Her personality was, in effect, erased.

Clinical Example No. 3

Mr. E. was a 32-year-old divorced man who came to treatment because of conflicts in his relationship with his girlfriend and the fact that he had had two unsuccess-

ful marriages in the past. The patient, an extremely intelligent man with many talents, worked as an actor in local theater. However, he never established himself in his career. He was living marginally, being financially supported by family assistance and some inheritance that financed his treatment. In addition to relationship and career difficulties, Mr. E. experienced some agoraphobic symptoms. He also experienced anxiety when attempting to take long walks or to jog around his neighborhood for exercise. He could describe the feeling only as that of being lost and anxious in the open space and needing to return to the comfort and structure of his home.

Mr. E. was the youngest of three children, with an older sister and brother. He spent his childhood in a small Southern town. His parents' marriage had been extremely troubled. Mr. E. described his mother as quite occupied with the older children and preoccupied with the marital situation during most of his early years. His mother also appeared to him to be a self-involved person who never seemed to "know" him as a person in his own right. Mr. E. described his father as relating to him in a very superficial way. Mr. E. was in treatment for a few months when he presented the following dream during the week of his birthday. At this time, he had begun complaining about what he thought was his difficulty in feeling any sense of emotional attachment to me or any connection between us. He saw me as rather detached and businesslike – a person with no real personal interest in him, someone who was just "doing her job." After describing these complaints, he presented the following dream:

I was biking over the canyon, which was a route I would regularly take going from one side of my hometown to the other. There was a ravine area that in the dream looked almost like a trench, very long and narrow. But this trench had glass around it like a greenhouse (hothouse). The light was very bright, almost white. There were many people who seemed to be lined up on either side of the corridors. It was difficult for me to get to the end. When I got to the end, I was concerned as to whether the children who were there would get out because I couldn't find their mothers. I wondered who was responsible. Was I responsible? Then I realized, no, the children weren't mine. Finally, at the end, my aunt showed up apologizing that she was late.

In association, the patient stated that from the time he was a young boy he would bike from one area of his town to the other through this canyon and that the area was sort of a crossroads in which one could go one of several directions. The ravine, with the people lined up, reminded him of a hospital corridor. He had had recent surgeries that were very difficult. He noted that the hospital corridor seemed crowded in the dream. The people seemed backed up against the wall on each side. They seemed fine in the dream, he said, but "I had the sense that there was some devastation, some catastrophe, the result of some war or perhaps the effects of a natural disaster." He further stated, "A greenhouse is a place where plants grow. Sometimes greenhouses have special lighting. I don't know about a bright white light though." Regarding the children at the end: "There was a question as to whether they would get out, as if somehow the effects of the disaster would prevent this, as if, in the commotion and confusion of the disaster, they couldn't get connected to their mothers and so couldn't leave."

He then said, "I feel like this is very important, as if something inside is going on, but I don't have the words to put to it." He went on: "I never did feel much

connection to my mother. She was absorbed with my older siblings and her troubles with my father. She seemed more like my aunt, who never seemed to me to be a very good mother and did not have much connection to her children. She was more occupied with her own needs in life. My mother was always 'showing up late' in relation to me, and I could never really understand whether this was my problem or hers." There was a long pause and then Mr. E. suddenly remembered that the ravine also reminded him of the place where his best friend had lived. This, too, was en route between one side of his town and the other. He visited his friend frequently. "This was my friend who died a terrible tragedy. I was very close to him before he died. He was a wonderful person, so bright and talented. His marriage worked out very well. He was very happy when his cancer was discovered. He died at 32. It was a devastating catastrophe." The patient then noted that this was his own 32nd birthday.

I suggested to Mr. E. that since it was his birthday and he had associated to the death of his best friend who died at the age he now is, the dream might be telling us something about his birth experience. At least that is where we could start in attempting to understand this dream. If this was about his birth, then possibly the ravine with the glass dome that was bright with people lined up against the walls of the sides of the corridor might be the hospital nursery – a place where newborns begin to grow; the lineup of people would then stand for the babies in the nursery. The glass dome might also represent the incubator with its warmth and bright lights. I wondered out loud if he had had any "disaster incubator" experience that would bring this imagery to his dream at this time.

He said, starting to cry, that he had had a very precarious beginning. His had been a normal birth and delivery in a hospital. However, he was initially jaundiced and had to be placed under special bright lamps. There was at the time a diarrhea epidemic on the ward, and within the first 24 hours of life, he came down with diarrhea. He was quarantined along with other babies. He became severely dehydrated and was treated with special equipment. He was not allowed any contact with his mother for almost 3 weeks. Instead, he was taken care of by one nurse in the nursery. His mother pumped breast milk, which he was fed from bottles each day. He subsequently was returned to his mother and then was released from the hospital. He remained a somewhat ill baby for the first month of life but gradually recovered and proceeded with normal development.

I suggested that perhaps we could understand the devastation (the war ravages in the dream) in the light of this experience. They would be the effects of the "natural disaster" in the dream, the jaundice and the diarrhea epidemic in the hospital. I felt that he had identified with his best friend, a bright, talented, and happy newborn who then suffered a "devastating catastrophe." The catastrophe was such that it was like a crossroads at which one could go in either direction, toward life or toward death. As an infant, he would not have known who was responsible for this terrible experience – he or his mother – or whether the jaundice and diarrhea were just natural occurrences of his body. I said that he must have worried, the only way a baby can worry – with feelings without words – that he would never become connected to his mother with all the commotion and devastation going on in his body. He must have also experienced her as a neglectful mother (represented in his dream by his aunt) who was not able to make contact

with him for almost 3 weeks and then showed up late with an apology at the end of the quarantine. Instead of having personal contact with his mother, he had to be taken care of by the impersonal nurse. Mr. E. then said that he thought this might be the feeling that he had not been able to put into words.

I said that I thought this was the issue currently in our relationship as well – the fact that he felt he could not make any personal contact with a caring-mother me. I was, instead, the impersonal nurse who was just baby-sitting him, so to speak, during this illness; not his real mother but the hired help just impersonally doing my job. The patient then reminded me that he had initially seen the analyst of a friend of his. He had wanted to see that analyst for treatment, but the analyst referred him to me instead. I was, then, the baby-sitter-nurse instead of the real mother. I said that as the baby-sitter-nurse I would have no real personal interest in him, and he would have no real attachment to me. I would be there just to keep him going and clean up his diarrhea, an unpleasant task at best. He must wonder whether he and I would ever get connected in the midst of all this bodily commotion. Would I finally “show up with an apology”? (That is, I must have been missing some very significant connections for at least the last 3 weeks, if not for the whole course of our contacts.) Would I finally realize and convey to him that this was the problem, that this was what had been going on? Mr. E. shook his head affirmatively.

In this hour I also took up Mr. E.’s birth experience in relation to his agoraphobic symptoms and, more generally, in relation to some of his difficulties in living. I said that he must still unconsciously experience himself as this ill baby. If so, then he could not really leave the house or take long walks. To go outside was to leave the safety of his home. His home stood for his mother’s womb – an “inside place” that was safe. In addition, his home stood for the hospital: a place where he became ill but also a place that was essential for his survival. If he went outside into life, he could risk illness and death. I thought also that he was still living as this precarious baby, marginally functioning in work and still quite dependent on his family, unable to function fully as an independent adult. He told me at this point that his chronic reaction to any stress was to get diarrhea. He noted at the end of the hour that this was the first session in which he had begun to feel some emotional contact with me.

Clearly, many factors other than this patient’s birth accounted for his difficulties. Almost immediately after this interpretation, however, he was able to begin to exercise and take long walks in his neighborhood. His complaints about my impersonal manner and his inability to make contact with me emotionally began to dissipate at this time.

Exactly on his birthday 1 year later, however, Mr. E. returned to the complaint about my impersonal manner. He had a dream that he was a janitor in a park. His job was to clean up outside and inside the bathrooms for the many people who visited the park. I believe he was saying here that from his birth he had been “stamped” or imprinted with the identity of the janitor for all the metaphorical bodily products of his family and those significant others to whom he was connected. His job in life seemed to be to clean up everyone’s anxieties, destructiveness, and projections, everyone’s diarrhea – that of his family and even that of mine. If I did not understand this problem, I was again just the cold, impersonal nurse. If he had such a job in life, certainly he could not go on with his own job of

being a baby who had the opportunity to grow and develop his mind and his own unique personality. Thus, he was still living in this “marginal state.”

By his birthdays in the third and fourth years of treatment, no such imagery of diarrhea or precarious states occurred in Mr. E.’s dreams, nor were there complaints about my detachment. He described satisfying birthdays with friends and many warm feelings. Birth material did not appear in his dreams. By this time, he had made substantial progress in his career and was establishing himself as an independent working person. His difficulties in identification with disturbed parental figures continued as the focus of the treatment. I believe the feeling of imminent diarrhea still occurs in situations of acute distress. We can see here the conclusions of Theodore Lipin (1955) and Lenore Terr (1991): Current physical symptoms may actually contain physical “memories” of early traumatic experience.

This material also addresses another important issue in psychoanalytic technique. It has often been stressed that the transference is the primary vehicle for analytic work (Gill 1982). The dream material of my patient was of enormous value in helping to ascertain the specific nature of the negative transference in operation at the time. All the factors involved, both past and present, became evident in depth through the specific associations and interpretations to the dream material presented in this hour. Understanding the dream also helped me to “touch” my patient emotionally in a most profound way, a way I believe would have been difficult to achieve without such an understanding. The transference – and my patient – were both reached through the dream.

Conclusion

I will now present a few thoughts, conclusions, and questions raised by the clinical material. Initially, very detailed analytic work with the dreams presented above had to be done to unearth the early traumas conveyed in them. However, once the traumas were discovered, rather than it being difficult to keep track of them, one could hardly get away from them. One could recognize them in somatic reactions, behaviors, symptoms, characterological manifestations, fantasies – conscious and unconscious – transference manifestations, and dreams. Essentially all the components of these individuals’ beings demonstrated and lived out these experiences.

From the research, analytic theory, and clinical data then, two stunning conclusions emerge about infant trauma:

1. Memory for infant trauma can be stored veridically and indelibly in a primitive memory system or systems such that it can be accessed through dream analysis and other psychoanalytic methods at a later point in time.
2. Infant trauma – coming so early in life – also forms memory schemas (Bartlett 1932; Paul 1967) or templates through which future development and experience is filtered. These templates or schemas then become an “organizing principle” (Stolorow and Atwood 1992) for the entire personality,⁵ coloring later ways of living, thinking, and seeing the world.

⁵ Clifford Yorke (1986) describes such an organizing phenomenon as a “post-traumatic neurotic-like state”.

Some of the experimental memory research (e.g., Graf and Schacter 1987) demonstrated that schemas help one to retain material because they form “meaning networks.” If such schemas are based on earliest trauma, then one could suppose that a “trauma meaning network,” so to speak, emerges right at the beginning of life. New perceptions, experiences, and objects are filtered through this meaning network. Future fantasies are formed from it, and future stances and perceptions of the world are shaped by its very presence

In terms of enduring memory for early trauma, Lenore Terr (1988) proposes an interesting hypothesis. She suggests that traumatic events create “burned in” visual memories even in infancy and even when trauma is not experienced visually. Visual memory (an unconscious form of memory) triggers behavioral reenactments along the lines of the repetition compulsion. “Visual memory,” she states, “seems to last a lifetime, and the tendency to remember behaviorally persists right along with it” (1988, p. 103). Larry Cahill (Cahill et al. 1994) at the University of California, Irvine, notes similarly: “The discovery [that emotionally charged experience and feelings sear a lasting impression in memory whereas ordinary experiences do not] suggests that the brain has two memory systems, one for ordinary information and one for emotionally-charged information” (p. C11). I believe it is this visual/behavioral, emotionally charged memory that endures in the infant’s unconscious and can be reconstructed in the course of adult psychotherapy and psychoanalysis.

In another vein, it may be that early severe trauma creates a very premature awareness that “mother is not-me” (via severe physical pain, separation from mother during hospitalization, sexual abuse, etc.). Such trauma then prevents the “illusion of oneness” with the mother so necessary for the baby’s sense of safety, security, and peace of mind. What occurs instead is a premature awareness of a separate bodily self. To deal with the terror of this experience, the trauma becomes encapsulated – preserved whole, and kept within the individual like a mental “autistic” object.⁶

Perhaps we could say overall that the therapeutic work between the patient and the therapist in which these traumas are identified, recognized, and understood would go a way toward reestablishing this missed experience of “oneness” between baby and mother so that the premature awareness of bodily and mental separateness from mother could be modified. The patient could then proceed with a normal psychological birth and his future growth and development.

It was also my sense that these patients as infants tried to protect themselves from this premature separate-self awareness by retreating to or never coming out of an “inside state of mind” or an “unborn mental state” (metaphorically speaking, they spent their entire mental lives in the parking lot garage, as noted by Mr. F.). There certainly appeared to be very little in the way of a psychological birth for these patients. The task of treatment was to help the patients “get born” into life and into the analysis, and interpretations had to be made to this effect in virtually all of the cases. According to Bail (1993, personal communication), getting the patients “born into life” is, in fact, a central task for every analysis.

⁶ See Francis Tustin’s (1981) work for an elaboration of psychological autism.

Some interesting questions remain. The individuals I presented in the book often had very troubled family situations. One would want to ask: How would birth and infant trauma be lived out in individuals with very attuned parent-infant upbringing, and doctors and hospitals equally attuned to the infant's needs and feelings? Would the results be less global? Would such attune parenting significantly modify the enduring impact of these traumas? How, in fact, are exceptionally good experiences at birth and in infancy manifest in dreams and lived out in personality? As Alvin Frank (1964) suggests, do they undergo a "change of function" and become ego strengths; or are they lived out in very specific ways only of a positive and growth-promoting kind? And, finally, how far back can we go? Perhaps in time we will discover that storage of early experience takes place not just from the beginning of life or from the fourth or fifth month of fetal development, but from the very moment of conception. Perhaps of all this, we are best to conclude:

Our unconscious is our universe and we have to accord it a vastness we may not always be able to comprehend as we cannot always comprehend the vastness of our physical universe. (Bail 1991, p. vii)

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