Psychoanalytic Dream Theory

Psychoanalysis as we know it began with Freud’s (1900) discovery of dream analysis. Dreams were, and I believe still remain, “the royal road to knowledge of the unconscious activities of the mind” (p. 608). Many of Freud’s specific theories regarding dream formation and dream interpretation required considerable revision, which they have undergone by contemporary dream researchers as well as by clinicians. Nevertheless, Freud’s basic understanding of the power of the unconscious mind to affect feeling, motivation, and action is one of the pivotal human discoveries of the nineteenth century.

Here we will review very briefly Freud’s dream theory. Then we will turn to more contemporary theorists for a brief overview of those who have addressed aspects of dream functioning specifically relevant to the subjects of this work and to the manner in which dreams are taken up in the clinical examples presented in the following chapter. Four frames of reference emerge (1) the dream as it represents the individual’s current state of mind and internal object world; (2) the dream as it represents real experience, including earliest experience; (3) the dream as it represents traumatic experience; and (4) the dream as it has adaptive and problem-solving functions. We will also cite some of the work of experimental dream researchers as well as the tachistoscopic studies of Otto Pötzl (1917), whose study we include for its contribution to the hypothesis that prenatal and neonatal experience may be registered in dreams.

**FREUD’S DREAM THEORY**

Freud (1900) postulated that the primary function of dreams was to provide discharge or gratification for impulses or wishes—usually infantile in nature and unacceptable to the conscious mind—and to do so in such a way that the process did not disturb sleep. During sleep, a person regresses to early developmental forms of drive discharge, such as hallucinatory wish fulfillment. Freud believed that if the forbidden infantile wishes were evident in the content of the dream, the material would be so distressing it would wake up the dreamer. Therefore he postulated a censor that disguised the dream wish and therefore preserved sleep.

In line with the wish-fulfillment function of the dream, Freud proposed that primary-process thinking operates in dream mentation. An unconscious form of thinking, primary process is ruled by the pleasure principle. Thus, wants are immediately gratified without regard to reality; rules of logic and syntax do not apply; and stable categories of time, place, and person are nonexistent.

Freud proposed several components to the process by which unconscious thoughts and feelings are transformed into a dream. He called this process the “dream work.” A “day residue” instigates the dream. The day residue is an experience, thought, feeling, or memory, usually of the preceding day, which may be trivial or emotionally significant (although a trivial element always stands for an emotionally significant one). The day residue makes contact with both current and past emotionally significant events and feelings, awakening an unconscious infantile wish. The wish is then transferred onto the day residue, which, particularly if it is benign, can escape the censor and take form in the dream.

The dream is represented by its manifest content, by a visual scene or series of scenes or impressions. The latent dream thoughts are thoughts that enter into and make up the dream and reflect the underlying motivations and conflicts of the manifest content. To unravel the latent meaning from the manifest content, one must use free association. One of Freud’s essential technical discoveries was that one had to ascertain the associations to each component of the dream, rather than to the dream as a whole, in order to unravel its underlying meaning (which Freud took at the time to be the dream wish). It is the associations to each element in the dream, as well as the associations within the hour itself, that unravel the distortion and “crack the dream code.” Many contemporary clinicians would no longer consider the central meaning of each dream to be an infantile wish. Freud’s specification, however, of the need for detailed associations to each dream element (as well as associations from the hour as a whole) remains of great importance, especially when early trauma is involved. As Greenacre (1952), Murphy (1958), Niederland (1965), and Terr (1988) have pointed out, early trauma may be stored in visual form. Thus, the experiences may be most readily ascertained through associations to the visual elements of the manifest dream.
The picture arrived at in the manifest content is accomplished through several mechanisms of the dream work that, according to Freud, distort the latent dream thoughts. These mechanisms are part of primary-process thinking. One mechanism is **condensation**, a fusing together of two or more images and is responsible for the fact that the manifest dream has a smaller content than the latent dream thoughts. Thus, for example, if one were trying to say that one’s spouse and one’s father have very similar personalities, that idea might be expressed in the manifest content of the dream by a fused figure: the face of the spouse, say, with the hair and dress characteristic of the father.

Another mechanism, **displacement**, is the transfer of one idea or image to another. With displacement, one can replace people, locations, objects, or feelings, substituting one for the other or parts for the whole. Thus one of my patients who was severely traumatized by the death of her mother when the patient was a toddler expressed the consequences of this experience for her psyche by a picture of a living room wall with a gaping hole in it. Two workmen were trying to figure out how to repair the hole. The large, empty wall left in her from such an early loss was “displaced” onto the picture of the wall with the hole. She and I were displaced onto the two workmen attempting to figure out how to repair such an early loss.

**Memorization** speaks to the fact that what is represented in a dream must appear in pictorial form. It has to be expressed in such a way as to be visualized. For example, to make a statement in pictorial form regarding something that happened a long time ago people may appear at a great distance and seem very tiny. Or the fact that something happened in childhood may be expressed by a little person sitting at a very large table.

**Symbolization** involves “a universal primal language representing an association between ideas” (Altman, 1969, p. 17). These ideas have in common what the infantile unconscious mind would consider similar (often forms, shapes, and sizes). In dreams, the referents for symbols are limited to “the basic and universal preoccupations of children: birth, death, the body and its functions, sexual organs, people, especially members of the family” (p. 17). Birth and pregnancy may be represented by immersion in water. A house with windows and doors may be the body orifices. Caves may be the womb, and so on. Finally, **secondary revision** involves the filling in of gaps following waking to make the dream appear more intelligible.

Freud (1900) saw the entire process of dream formation as an attempt to make contact with early infantile experience, needs, and wishes.

If we now bear in mind how great a part is played in the dream-thoughts by infantile experiences or by fantasies based upon them, how frequently portions of them re-emerge in the dream-content and how often the dream-wishes themselves are derived from them, we cannot dismiss the probability that in dreams too the transformation of thoughts into visual images may be in part the result of the attraction which memories couched in visual form and eager for revival, bring to bear upon thoughts cut off from consciousness and struggling to find expression. On this view, a dream might be described as a substitute for an infantile scene modified by being transferred onto a recent experience. The infantile scene is unable to bring about its own revival and has to be content with returning as a dream [p. 546].

Freud initially saw all dreams, including anxiety dreams and dreams with very unpleasant content, including punishment dreams, as representing wish fulfillment in terms of the latent dream thoughts. He staunchly maintained this view until he saw World War I veterans suffering from severe posttraumatic stress. The dreams these veterans were having could not have been a result of wish fulfillment and could not be conceptualized as regulated by the pleasure principle inasmuch as the dreams were detailed reenactments of traumas that the veterans had experienced in the war scene (see Lansky, 1991, for a different view). Freud (1920a) revised his theory, but only somewhat, stating that traumatic dreams represented attempts to master trauma in a retrospective manner. Freud postulated that mastery of trauma represented an earlier and more fundamental function of the mind than the wish-fulfillment function.

Freud’s understanding of dreams was thought to be so complete at the time that clinicians and researchers were slow to revise his original views. In addition, the psychoanalytic community gradually moved away from a focus upon the unconscious as revealed in the dream to the study of the ego and the mechanisms of defense. Interestingly, analysts ranging from Sharpe (1937) to Sloane (1979) and Meltzer (1984) have protested this trend and offered various explanations, generally centered on defensive processes in the analyst, to account for it. Greenson (1970) noted that fewer analysts had their dreams systematically investigated in their own training analyses. The manifest content of dreams became prominent, and attempts to elicit detailed associations to the dream elements and to provide interpretations that included a synthesis of the whole dream diminished. Thus, dreams came to be considered no more important than any other type
of communication in the analytic hour (see Altman, 1969, and Greeno, 1970, for a discussion of this point of view). In the 1950s the work of laboratory dream researchers sparked a renewed interest in dreams, but from the perspective of the physiology of dreaming. The results of their efforts directly challenged some of Freud’s assumptions about the basis of dream formation.

**DREAM LABORATORY RESEARCH**

**Eugene Aserinsky, Nathan Kleitman, and William Dement:** REM Sleep

In their studies of electroencephalographic changes of sleeping subjects, Eugene Aserinsky and Nathan Kleitman (1953) and William Dement (1955) showed a connection between REM sleep activity and dreaming. Their studies demonstrated that REM sleep occurs regularly throughout the night. It produces a pattern of four or five dreams per night on a regular basis. Dreaming is a universal phenomenon, regardless of recall. Their results suggest that dreaming is essential to human functioning (see also Roffwarg et al., 1966). It has an integrative and adaptive significance that is more fundamental than that of infantile wish fulfillment or drive discharge. The function of dreaming as being to preserve sleep was challenged by these studies. A more accurate description would be that “sleep is the guardian of dreams” (Greeno, 1970, p. 521).

**J. Allan Hobson and Robert McCarley:** The Neurochemistry of the Dream State

J. Allan Hobson and Robert McCarley (cited in Begley, 1989) studied the neurochemical functioning of the brain in the sleep state. They hypothesized that dreams are generated in the brainstem. Two different neurons are involved in the function of sleep: one uses acetylcholine, which is active during REM sleep; the other uses norepinephrine and serotonin, available in non-REM states. When the latter are inactive, acetylcholine neurons generate a dream by sending electrical signals to the cortex. The cortex, the center of complex thought as well as of vision, makes use of the electrical signals to create a visual story. Memories from the past are used to create the story and appear as if they are happening in the present. Hobson (1988) emphasizes that the brain is engaged in making meaning of experience. From his activation-synthesis view of brain functioning, he considers the brain to be “inexorably bent upon the quest for meaning” (p. 15): “the human brain-mind . . . does its best to attribute meaning to the internally generated signals. It is this synthetic effort that gives our dreams their impressive thematic coherence” (pp. 212–214). Dispensing with the idea of a dream censor, Hobson argues that the brain-mind works metaphorically; thus dreams can be interpreted in this light. He suggests that since we dream in metaphors, human knowledge may be processed similarly (cited in Begley, 1989). That the dream works with remote experience, meaning, and metaphor is very significant. It suggests that dream analysis has the potential to reveal the unconscious meaning of one’s earliest experience in metaphorical terms.

Hobson’s clinical use of the far-reaching potentiality of the dream is limited, however. He makes use of the dream in its most transparent and unedited form. No distortion is considered important, and no distinction exists between manifest and latent content. He provides examples of the manifest content of dreams in which meaning is interpreted at the most superficial manifest level. For example, Hobson dreamed he saw Mozart play at a museum concert and was eager to tell his wife. Hobson interpreted this to mean that he would very much like to see Mozart play at the museum and would also enjoy his wife’s getting credit for arranging such a feat. It appears that, although Hobson understands the functioning of the brain in sleep states, in his approach to dream analysis, he has underestimated the depth and complexity of the unconscious mind and its contributions to true human meaning. He does, however, allow that more profound unconscious understanding can be derived from dreams. He just does not feel it is necessary to pursue it. His approach to dream interpretation precludes the possibility of retrieving early experience to bring alive for the patient and the analyst an understanding of current personality.

**CLINICAL CONTRIBUTIONS**

Analysts and psychoanalytic psychologists have made many valuable contributions to the revision and expansion of Freud’s dream theory. According to these authors, dreams can reveal much more than a forbidden wish, the mechanisms of dream formation providing only attempts to disguise. Dreams can illuminate one’s internal world,
ones’s self-representations; they can portray real and traumatic experience and explicate the range of efforts made by a person to solve essential human dilemmas in facing life’s vicissitudes.

In his theoretical work on dream formation, Richard Jones (1970) attempted to recast some of Freud’s more restrictive theories. For example, Jones addressed Freud’s wish-fulfillment hypothesis and his concept of the distorting function of the “dream work.” Jones noted that REM sleep may be conducive to the stimulation of unconscious wishes. Thus, repressed wishes may be incorporated into dreams. REM-state research has made it clear that repressed wishes do not initiate dreams, however, as was Freud’s view. Jones suggested that the “dream work” is really a transformative process rather than a process that only distorts for defensive purposes (i.e., for purposes of disguise). According to Jones, dreaming involves a transformation of both recent and past mental content into new forms. A disguise may be one form, but a revelation may be another. Niederland’s (1965) case of a schizophrenic young man may be taken as an example of the latter possibility. The dream elements include the patient’s lying on an ice block that serves as a bed at the North Pole. The ice block and the North Pole provide the most graphic depiction, not disguise, of this patient’s actual frozen experience in infancy. They helped to reveal rather than distort his early trauma.

Dreams as Revelatory of the State of the Mind and the Internal World

According to a number of analysts, dreams also present graphic portrayals of one’s state of mind, one’s internal world. Dreams provide us with the most “condensed, vivid and complex specimens of the conflictual intrapsychic, intrasystemic, as well as the interpersonal experiences in any given individual” (Khan, 1976, p. 328). I believe that Fairbairn and Rycroft captured the essence of the dream most succinctly: Dreams are “dramatizations or ‘shorts’ (in the cinematographic sense) of situations existing in inner reality” (Fairbairn, 1952, p. 99); the dream reveals in pictorial form “the total psychological state of affairs existing at the time the dream was dreamt” (Rycroft, 1979, p. 11). This current “total psychological state of affairs” includes the continued mental presence in adult life of earliest experience. Rycroft in particular emphasized that the dream requires some distortion in order to represent thoughts in pictorial form. It is the necessity to represent thought in visual imagery as opposed to the need for disguise, that he sees as accounting for the fact of distortion in dreams.

Mancia (1988) also saw the dream as furnishing a general “organization of the internal world with the function of representing . . . the internal objects” (p. 419). According to Mancia, dream work transforms emotional experience into knowledge, a view held by Bion (1962) and Meltzer (1984). Wrote Mancia:

During the course of the process of analysis, dreams become a newspaper that has to tell the truth every night without fear, revealing moment by moment the state of our government—i.e., the state of our minds—represented by the internal world peopled with internal objects with their own values and relations and their own economics and politics [p. 422].

According to Bail (1993, personal communication), dream analysis by bringing to the individual an understanding of the deepest layers of the unconscious mind, promotes the growth of the mind itself and of the personality.

Kohut and Atwood and Stolorow further developed the idea of the revelatory aspect of dreams. Kohut (1977) saw the “state of dream” as portraying in its manifest content the dreamer’s current psychological state, primarily “the dreamer’s dread vis-à-vis some uncontrollable tension-increase or his dread of the dissolution of the self” (p. 109). Atwood and Stolorow (1984) see another purpose to the self-state dream:

The dream symbols bring the state of the self into focal awareness with a feeling of conviction and reality that can only accompany sensory perceptions. The dream images . . . both encapsulate the danger to the self and reflect a concretizing effort at self-restoration [pp. 104-105].

They propose that concrete symbolization in dreams serves an extremely important purpose:

The dream affirms and solidifies the nuclear organizing structures of the dreamer’s subjective life. Dreams . . . are the guardians of psychological structure, and they fulfill this vital purpose by means of concrete symbolization [p. 103].

Dreams as They Represent Real Experience

Ella Sharpe (1937) emphasized the role of actual experience in dreams as opposed to just forbidden wishes.

Dreams should be considered as an individual psychical product from a storehouse of specific experience, which
indeed the dreamer may in consciousness neither remember nor know that he knows. The material composing the latent content of a dream is derived from experience of some kind. All intuitive knowledge is experienced knowledge [pp. 14–15].

She included in her definition of “experience” occurrences that had happened in the past, and the affective states and body sensations accompanying these occurrences. She also saw dreams as representing the body ego from the earliest years. Leo Rangell (1987) agrees with her. For him also, dreams are a significant source of data for reconstructive work, especially because of the capacity of dreams to address the preverbal period, including early sensory memories. Similarly, Clifford Scott (1975) noted the important function of dreams in allowing the past to emerge, including memories from the infantile body. He stated of dreams in the latter stages of analysis: “Patients often seem to come close to finding in a dream a better understanding of the story of their lives than of anything they have ever understood before” (p. 325).

Stanley Palombo (1978) addressed the continuous role of actual experience in dream formation. He hypothesized that dreaming serves an important function for the memory cycle in which new experiential information is introduced into the permanent memory structure:

The most striking hypothesis of the memory-cycle model is that the critical step in the sequence—the step which matches representations of new experiences with the representations of closely related experiences of the past—takes place during dreaming [p. 13].

**Dreams as They Represent Early Traumatic Experience**

Ferenczi (1931) suggested that dreams involve mastery of traumatic memories as one of their primary functions. He noted that the state of sleep is conducive to the “the return of unmastered traumatic sensory impressions, which struggle for solution” (p. 240). His understanding of this function of the dream is particularly evident in the clinical examples presented in this book. Sharpe (1937) saw dreams as particularly useful in retrieving traumatic experiences in infancy. Thomas French (1970) noted that the original response to a traumatic memory becomes a pattern of reaction that can be stimulated by situations only somewhat similar. These patterns are resistant to modifications from later experience. They are repeated in dreams and become the focus of the dream’s problem-solving efforts. Dreams are not merely wish fulfillment, but they describe present realities that are disturbing to us.

Angel Garma (1946) viewed traumatic situations as the instigators of dreams, a view quite different from Freud’s idea that infantile wishes are dream generators. Traumatic situations include traumatic experiences from childhood. Garma’s position was that trauma contributes to all dreams. “In the interpretation of dreams, an attempt should always be made to find the basic traumatic situation” (p. 137). Garma saw the dream wish as an attempt to overcome the “psychic displeasure” brought about by that which is traumatic to us.

Dreams following a trauma are significant because they include not only the reality of the traumatic experience, but also the important fantasies connected to it (De Saussure, 1982). Dreams, then, can help us to see in what particular ways the experience was traumatic for a person. Janice De Saussure touched here on how the dream has the potential to tell us the unconscious meaning of a trauma to a person. She also noted that a traumatic dream (i.e., a repetition of a terrifying event in a dream) can constitute a trauma in itself.

Dowling (1982a) discussed a type of prerepresentational childhood traumatic dream involving “image-less terror and diffuse feelings of loss and emptiness” (p. 165). The imageless-terror dream represents, in Dowling’s view, experiences and feelings from before the mental structure became sufficiently developed to form a representational dream, that is, two years of age and younger. This type of dream makes use of preprimary-process mentation, largely in the form of sensorimotor organization and mental experience similar to the Lewin (1946) and Isakower (1938) phenomena.

Notwithstanding Dowling’s assertion that the unconscious mind is not sufficiently structured prior to 18 months to form a representational dream, Milton Erickson (1941) reported two dreams with distinctly identifiable psychic and affective content from a child first at eight months of age and then at 13 months. This child clearly was replaying in her dreams a happy memory of an ongoing nighttime play sequence with her father. Each night, she would laugh during their game and move her head and legs in certain positions accompanying the laugh. When the father was absent one evening when she was eight months old, after many months of this pleasant ritual, the child was found dreaming, moving her head and limbs and merrily laughing in the identical manner to her usual game with father. This was repeated at 13 months.
Melvin Lansky (1991) addressed the role of shame and dissociation in the instigation of posttraumatic dreams. Lansky, considering current day residue in dealing with posttraumatic dreams, suggested that even posttraumatic dreams have meaning in terms of the current life of the person and are not just a “replay” of past trauma. The meaning may encompass intense feelings of shame that took place during the dream day (thus serving as the day residue) and that are then transformed into fear in the dream and linked to the posttraumatic situation. The posttraumatic situation can serve as a screen for many other traumas, including infantile ones. “The posttraumatic nightmare, however disturbing, screens out experiences of shame, often from a lifetime of traumata” (p. 487).

Dreams as They Represent Problem-Solving and Adaptive Functions

Several writers have described dreams as having adaptive and problem-solving functions.

A wish may, for example, be one solution to a problem with which a patient is struggling, but dreams can portray a range of both successful and unsuccessful unconscious efforts to deal with emotionally significant issues, going beyond efforts to disguise unacceptable impulses (Greenberg and Pearlman, 1975).

Frederick Weiss (1964) commented on the depth of human meaning evident in dreams:

The most powerful motivations for dreams, however, are feelings of frustration and guilt—not the frustration of neurotic needs for power in “love” or the neurotic guilt associated with falling short of perfectionist standards. I am speaking here of feelings of existential frustration about un-lived life and of existential guilt about unrealized potentials in ourselves. Repetitive dreams are not caused by the work of a fatalistic repetition compulsion. Instead, they repeatedly challenge the dreamer with the vital problems in his life until these are confronted and solved [p. 23].

Weiss noted the creative function of dreams. The dream is, he wrote, “a creative act in which the dreamer’s striving, conflicts and attempts at solution are crystallized. The past enters the dream as a dynamic symbol of the present” (p. 25).

Thomas French and Erica Fromm (1964) proposed a problem-solving theory of dream motivation. They saw the central purpose of dreams as an attempt to find a solution to an interpersonal (rather than a strictly intrapsychic) problem. Earlier, similar problems emerge around the central problem. French and Fromm’s methods are cognitively oriented in their focus on the adaptive and problem-solving nature of dreams to deal with past or present unresolved conflicts.

For Edward Tauber and Maurice Green (1959), “the dream appears to express man’s way of organizing life experience and his inner reflection of himself” (pp. 170–171). They regarded the dream as a “metaphysical statement of a problem-solving issue, as an attempt to say something about one’s way of life and about one’s conception of one’s self as a human being” (p. 171). They considered the impulse-discharge function of the dream as too limiting; the interpretation of dreams should always “aim to expand the meaning of the dreamer’s life (p.177). . . . Can the core problem, the central focus or false solution of this man’s existence, be identified?” (p. 179). A similar conclusion was drawn by Greenberg and Pearlman (1980), who concluded that dreams are dynamic because they are part of a struggle to make emotional sense of our experiences. . . . It seems to be a process in which the dreamer struggles to make sense of and thereby master his life experiences, while maintaining a continuing sense of himself in relation to the world. It begins with high levels of REM sleep at birth and persists throughout life. It shows evidence of both successes and of failure and is an accurate portrayal of life as the dreamer experiences it [pp. 94–95].

OTTO PÖTZL’S DREAM EXPERIMENTS

Although the laboratory research of Otto Pötzl (1917) is not germane to dream theory per se, the results of his experiments imply the possibility that infant experience in stored and retained in REM states. His studies demonstrated that experiential data may be integrated into memory storage without the requirement of a developed mental structure (e.g., conscious secondary-process thinking) for its processing.

Pötzl, beginning in 1917, conducted experiments demonstrating that visual stimuli presented tachistoscopically for a hundredth of a
second underwent perceptual registration and transformation into a memory trace. Subjects in this experiment were shown tachistoscopic pictures and then asked to record their dreams the night of the experiment. Parts of the stimulus pictures that were not consciously perceived appeared in the manifest content of the subjects' dream material. Interestingly, parts of the pictures that were consciously perceived were excluded from the dreams. Pötzl's findings provided evidence that there is "unconscious cognition without awareness" (Fisher, 1960, p. 95). The memory images of the unconsciously registered elements in Pötzl's studies were either photographic duplications of part of the originally exposed stimulus picture or the stimulus picture transformed and distorted in a manner quite similar to the primary-process mechanisms of the dream work.

I believe that the findings of this early dream research are extremely important. If we have unconscious cognition and this cognition can be stored in our dreams, then we truly have a world of knowledge derived from unconscious perceptions that are preserved. Most important for our purposes is that Pötzl's results may apply to infants—even newborns, even fetuses; REM sleep begins in utero (Roffwarg et al., 1966). Recall Milton Erickson's (1941) report on the occurrence of a dream with definite psychic and affective content in a baby as young as eight months of age. If subliminal perceptions register in unconscious dream content, then perceptions from the first months and year of life, and perhaps even from the womb, could be registered in the mind in the subliminal manner found in Pötzl's work. Because this type of subliminal registration bypasses secondary-process thinking, the lack of a developed mental structure in the infant or fetus would not by necessity preclude registration and storage of experience in infant dreams. If the perceptions or experiences are of a traumatic kind, they may be especially likely to be registered and stored in dreams and then reappear through time in the course of adult analyses. It is this capacity for perceptual registration outside of conscious awareness that is the key to understanding how dreams can store human experience from the very beginning of life.

SUMMARY

Almost all the authors discussed here went beyond Freud's drive-discharge, wish-fulfillment function of the dream to take up dreams' much broader and deeper potentialities. Several writers view traumatic experience as the fundamental content of dream formation. Actual experience from infancy, including emotional and somatic components as well as external experience, were described by a number of the writers. The capacity of dreams to deal with human meaning and metaphor allows the process of dream analysis to bring both knowledge and growth of the mind to the individual. A significant purpose of dreams is to make emotional sense of one's experience, to allow one to grapple with the anxieties generated by what has not been solved (including earliest traumatic experience).

Perhaps most salient the central questions of this work are the tachistoscopic studies of Otto Pötzl (1971). His findings lend support to Mancia's (1981) hypothesis that data of a psychological nature may be transmitted to the fetus (and the infant) by way of REM sleep, forming internal representations and a "protomental nucleus." REM states (dreams) may, in fact, be one "place" (thalamo-amygdala circuits being another) where "memories" of earliest experiences, feelings, and needs are stored. Since the amygdala stores simple feeling states, such as fear, and the dream stores perceptions not in conscious awareness, infants and fetuses may actually have the mental structures available to "know" their experience in some primitive form and to retain it in their beings. Unconscious perceptions, for example, of the mother's mental state, may be processed directly in REM and in the amygdala. Hence, a baby's "exquisite attunement" to the state of its mother. The baby knows its emotional and perceptual world. It is the problem of the adult world to determine how to decipher it.
9
Reconstruction of Infant Trauma from Analytic Dream Material
Clinical Examples

This book is based on the premise that birth and infant trauma can be reconstructed from dreams. Such material can be gathered by means other than dreams, for example, nonverbal behavior within the analytic hour (Anthi, 1983); symptoms and behavior (Robertiello, 1956); and transference manifestations (Cohen, 1980). I feel, however, that dream analysis offers a very rich opportunity to see the unfolding of the specific nuances and details of a patient's inner world, including his or her actual experiences, feelings, and fantasies. It is possible that through dream analysis we will be able to see the "story" of early traumatic experience and an expression of the meaning of such experience for the patient in metaphorical terms. Dream life, according to Meltzer (1984), is the generator of meaning. Thus, in studying dream life, we are studying the life of the mind.

The method used in the analysis of the dreams of the patients presented here involves some of Freud's (1900) rules of dream interpretation: ascertaining the day residue; following the patient's associations, both in the hour as a whole and to the specific elements of the dream; and attempting to unravel the latent dream-thoughts from the manifest content. The impetus for the dream, however, was not seen primarily as an infantile wish. In this respect, the interpretations followed the conclusions of more contemporary theorists who suggest that dreams may represent snapshots of the patient's endopsychic situation (Fairbairn, 1952; Rycroft, 1979) or a problem to be solved (French and Fromm, 1964; Greenberg and Pearlman, 1975). More specifically, one might say that the dream shows us the central unconscious anxiety or "state of affairs" to be addressed in any given analytic hour: it brings us to the point that which must be known at the current moment for the patient to "grow his mind" and to "move forward" in life (Bail, 1993, personal communication). Each interpretation, then, addressed the central unconscious conflict/anxiety/disturbing endopsychic situation as it could best be ascertained from the dream, its accompanying associations, and transference manifestations.

Certain assumptions about the unconscious underlie thinking about the material presented by my patients in their analytic hours. First, the unconscious stores everything from the beginning of life to the present. As Freud (1940) said, "The id contains everything that is inherited, that is present at birth, that is laid down in the constitution" (p. 145). The unconscious stores actual experience and memories as well as impulses and fantasies (Sharpe, 1937; Palombo, 1978); and actual experience can and should be distinguished from fantasy and wish (Bail, 1993, personal communication). The manifest content of a dream may be a depiction of an experience or psychological state rather than solely a disguise (Jones, 1970).

The method of dream analysis, the assumptions about the unconscious, and the particular way of understanding patient material have been put together in a method of relating to the unconscious derived from the work of Bernard Bail. This method of dream analysis is distinctive in that it focuses on the importance of gathering all possible associations to the dream and in the fine detail with which these associations are treated.

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 [Reiner, 1993, personal communication].

In all the examples presented, the traumas of birth and infancy were unearthed during the process of analyzing dreams. The material from the dream analysis was then linked to behavior, symptoms, character, and transference manifestations when possible and appropriate. What became evident in the hour was that experiences of the distant past remained powerfully alive in the immediate present.

The clinical material involves presentations of "moments in treatment" rather than the course of treatment itself. These moments include primarily only the actual dreams from which the infantile traumas were ascertained and only the specific information about the patient that was necessary for an understanding of the early trauma and the manner in which it was currently being lived out. Invariably a concern emerges in presenting one's clinical work: how do we insure
the privacy and confidentiality of our patients and at the same time share enough of the process to bring new knowledge to the field and advance clinical skills? I hope the attempt here has provided a meaningful balance, although it is weighted on the side of patient confidentiality. Thus, all identifying information has been deleted to protect each person's identity. The case histories of these patients and the process of their treatments, including the process involved in the hours actually described, were much more involved than could be presented here. In all the cases, many unconscious issues had to be analyzed to bring about substantial improvement. Such significant editing of the material as I have done brings to bear an impression of simplicity upon very complex material and an equally complex analytic process. It was, however, necessary for purposes of confidentiality as well as for considerations as to the length of this text.

Another point should be made. In bringing together here only a collection of cases in which traumatic birth or early infantile traumatic experiences were of significance, it can appear that all patient material is routinely analyzed in this fashion—that is, everything is taken back to birth. This is not the case. In fact, relatively few of my own cases over the course of the past 13 years have involved actual physical trauma at birth and interpretations to that effect. Some of the cases have been presented in this collection. Many more long-term strain traumas involving parental misattunements have presented themselves but are not reported here.

Example #1 (Ms. A) reconstructs an actual physical trauma at birth. Example #2 (Ms. B) reconstructs a physical trauma in the neonatal period. Example #3 (Ms. C) illustrates the emotional meaning of a long-term strain trauma beginning at birth. Example #4 (Ms. D) reconstructs a sexual molestation in infancy. Example #5 (Mr. E) reconstructs primarily an "environmental trauma" impinging on an infant at birth. Example #6 (Mr. F) illustrates the reconstruction of both the fact and the meaning of a very premature delivery. Example #7 (Mr. G) illustrates the combined effects of the trauma of a parental death at the time of the patient's birth and an overstimulation trauma in infancy. Example #8 (Mr. H) illustrates a patient's having "loosened the bonds" of his traumatic beginnings during the course of a 10-year analysis.

In one case (example #1, Ms. A), the patient was unaware of the birth trauma at the time of the dream and learned about it when she went to get confirmation of the dream interpretation from her mother.

One patient (example #4, Ms. D) suspected (actually the patient's mother suspected) that she might have been sexually abused by her father as a child; however, the patient had no recollection of such an experience. In another case (example #7, Mr. G), the patient learned as an adult that he had been given repeated enemas by his disturbed grandmother but had no recollection of receiving the enemas. In another case (example #2, Ms. B), the process of analysis actually brought to mind a lifelong behavioral pattern that had not been mentioned previously, and the patient mentally connected this pattern to the early trauma for the first time. In the remaining cases, the patients knew of their traumas through information given them as children by their parents. In these cases, dream analysis elucidated the most significant emotional meanings of their traumas—how the traumas affected the patients' lifelong struggles to live in the world and be born psychologically.

Dream analysis illustrated how the transference was colored and shaped by the patients' traumatic beginnings. In addition, the material seemed to demonstrate how the analyst's actual understanding or initial lack of understanding of these experiences were perceived by the patient unconsciously. Elucidation of this for the patients seemed to be an especially important part of the analytic process. It allowed the patients to feel that the analyst was willing to continue to make contact with them even if such contact involved unfavorable or unflattering perceptions of the analyst.

In most of the cases, the dreams were precipitated by an actual event in the patient's life, usually the patient's birthday. In two of the cases (clinical examples #6, Mr. F, and #8, Mr. H), however, the dreams were precipitated by a "change in ego state" (Niederkz, 1965). In other words, the patients had made a significant change in state of mind, and the dream seemed to provide a commentary on the profound meaning of that change.

CLINICAL EXAMPLES

Clinical Example #1: A Physical Trauma at Birth

Ms. A was a 44-year-old female lawyer when she came to treatment with difficulties adjusting to a move to Los Angeles from Canada,

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1To preserve confidentiality, some associations to the dream elements in the eight

2I would like to extend appreciation to Dr. Lorraine Gorlick for her valuable consultation on the first two clinical presentations of this work.
where she had lived all of her life. She was the second of four children, with one older brother and a significantly younger sister and brother. From the descriptions of her interactions with her parents, one got the impression that they were distant, "stilted" people who did not seem to have a real feeling for how to relate to children. Ms. A had been divorced with one child following a marriage in her 20s. She was a warm, caring, and very intelligent woman whose troubled internal life clouded the many gifts she possessed.

In the initial weeks of treatment, and for a time before entering treatment, Ms. A had been fending off a significant depression by taking stimulants and mood-elevating drugs. These drugs were now beginning to have damaging physical consequences. Though intellectually gifted and quite capable in her field, she was unable to complete her legal briefs until the very last moment. This "last-minute pattern" led to complications in her work situation. New to the city, she began frequenting nightclubs in order to meet men with whom she could have a relationship. She would stay at the clubs until 2 o’clock in the morning, have a sexual encounter with someone she met, and then hope the man would call back to continue contact. She was mildly physically harmed on one occasion. Some of her money and possessions were stolen in another. In the countertransference, I had the feeling on hearing about these experiences of "holding my breath," so to speak, of waiting for a catastrophe. I never knew from session to session what would happen. Would she be seriously hurt in one of these encounters? Her employment was, at least metaphorically, equally precarious. Her failure to come through with assigned projects until the last moment nearly led to her being fired.

It seemed to be the "nearly" that was so important in my patient’s internal life. She managed to come through, to save the situation at the last moment. No catastrophe actually happened—it just "nearly happened." I began to be occupied with this "nearly." What was it? Why was I always "holding my breath"?

Ms. A had not presented dreams in the initial weeks and months of treatment, and I was not initially focused on dream work as a significant aspect of the therapeutic process at this time. Thus, the interpretations I was making were without what I would now consider the benefit of a true perspective from the unconscious. One day, however, during the week of her birthday, and while discussing her near-firing at work and a nearly abusive experience with a man she had just met in a night club, she spontaneously reported the following dream.

I was at my home, and my mother dropped off a birthday gift for me at the door. I picked up the gift from the door and unwrapped it, and there were three decorative baskets. One was beige, a second was blue—a blue-gray, actually—and the third was also beige. They were decorated attractively with flowers in and around them, and were arranged in the specific order of the blue basket between the two beige baskets.

Her associations were as follows:

My birthday is approaching in several days. I think that is why I had the dream. I don’t particularly look forward to my birthdays. They remind me of what I have not accomplished in life: a satisfying relationship, career, and freedom from the turmoil I experience just trying to go about living my life.

[Her mother drops off the gift at her apartment]: My mother would be giving gifts to us on our birthdays. She always did the right thing that way. She had unusual ideas about raising children, like toys were not necessary. Only educational items were important.

[The door of her apartment]: It is to the door of the apartment I live in now that she leaves the gift. The apartment also has some sense of the home I lived in when I was a young child: the first home I lived in. I cannot see details of the home in the dream—just the gift at the door: I have some decorative baskets in different colors. They’re attractive but don’t hold any special importance to me. None of them are beige or blue. The colors don’t mean anything to me either. I have no particular reaction to or feelings about them. I don’t particularly like them or dislike them. They are not “my colors,” so I am not sure why my mother picked them. Blue is sometimes meant for a boy but I was not supposed to be a boy. There are four siblings. The second and third siblings are girls. I am the second of four, not really considered “the middle.”

[Why were three baskets involved?): Nothing of three comes to mind as important—nothing at all. What comes to mind about something in the middle or center between two things that are the same?) Nothing at all comes to mind about this. No sibling stood out as strikingly different from the others. I can’t make anything of this configuration.
[The flower arrangement in and around the baskets]: They were an arrangement of flowers like you would send to someone as a birthday present or presents for some other special occasion. No particular kinds of flowers stand out. I just have an impression of flowers to indicate it's a birthday present.

I was left here with very few associations. Her mother had dropped off a birthday gift for her at the time of her birthday, but there with no associations to the unusual configuration of the gift. Her mother was proper and provided intellectual stimulation but not emotional contact for her child. The home in the dream combined that of her infancy and her current life. What could one make then of this dream? The most significant and clearest aspect of the dream was that it involved her birthday. Both the day residue to the dream and the actual gift in the dream centered on this event. I wondered, could the dream be presenting something to us of her birth, of, in fact, her actual birth day? I asked her if she knew of any of the circumstances or details of her birth. She said that she thought the delivery was on time, but she really knew nothing much about it. Her mother was a rather closed person. They had very few talks about anything personal. The patient's conscious knowledge, then, was not of help in deciphering this possibility.

I thought to myself that if the dream was about her birth, then understanding it had to come from the form of the gift and other associations to the dream itself as well as her general associations within the hour. From the dream, "three" had no meaning; something contrasting between or in the center of two similar things had no meaning. Perhaps, then, the arrangement of the gift represented a sequence: one thing or experience followed by a different or contrasting thing or experience, and then a third that was identical or very similar to the first. In the hour, I was again "holding my breath," waiting for a catastrophe as she was reporting that her delays in completing litigation work on a case involving sudden infant death syndrome had now led to probationary status with impending dismissal if things did not change. She also spoke of a brush with abusiveness from a man she had slept with the night before.

This material led me to think that perhaps a catastrophe or a "near catastrophe" was involved—analogous to a near "sudden infant death." I thought of babies at the time of birth. We know them by the response of their bodies. We do not yet know them by their minds or their feelings. Medical decisions are made on the basis of how their bodies respond. Perhaps some near catastrophe of the body had occurred at birth. Babies turn blue (or blue-gray) when they are in distress, particularly when they are deprived of oxygen (I recalled that I was literally holding my breath); otherwise, they have normal skin color, which, for a Caucasian infant, approximates beige. The baskets with flowers could represent fetus/womb imagery. This dream, then, might be imagery representing an actual, concrete experience involving severe distress or a near-catastrophe on the birth day.

I told the patient that one possible understanding of this dream—and it was just that, a possible understanding—surrounded her birth itself. The dream might be saying something to the effect that at her birth she was beige (having normal skin color) but had turned blue at least for a bit of time, and then returned to beige—meaning that there had been some problem, perhaps one that had led to near-death at the time of her birth. The patient recalled nothing at the time but seemed interested. In the brief time left in the hour, we continued discussing her current reality and its possible meanings.

Ms. A contacted her mother at some point following this session. Her mother informed her that she had had difficulties with her pregnancies, that there had been two miscarriages prior to Ms. A's birth. There had been an incompetent cervix. During the pregnancy with my patient, a procedure to attempt to hold the cervix together was performed. The doctor delivered the baby early by Caesarean section. An obstetric specialist was called in. No other details were provided.

If some precarious beginning had actually occurred (and, again, what had happened was not exactly clear), then could we consider Ms. A's continuous near-catastrophic behaviors in the light of this? I wondered, could she have been acting out her "life-and-death" birth in this way? Certainly, her mother's two prior miscarriages and the doctor's concern about delivering Ms. A early indicated that considerable anxiety would have existed in the mother as well as in the doctor. There must have been some concern throughout that the baby just wasn't going to make it. She had not been born in the usual way and had, in fact, been lifted or pulled out before she was ready.

Ms. A was consistently late on projects because she wanted to do things in her own time, not on the schedule of others. I said to her that perhaps she could not accomplish major life events in the usual and gradual way and still feel that the progress belonged to her. She was always in a "blue state," so to speak, moving into an "beige state" only at the very last second and with enormous amounts of therapeutic and other interventions. We do not know if there had, in fact, been
a "blue state" (oxygen deprivation) but there certainly seemed to have
been a feeling state of impending or threatened danger to life before
or during the time of the delivery. The home in the dream was a
combination of the home of her infancy and her current residence. We
could say that some precarious experience happened at her birth (in
her infancy), and was still being lived out metaphorically in her
contemporary life (her present home).

The transference implications seem quite important here. I told Ms.
A that if I was not understanding the profound nature of her early
experience, then I was just like the incompetent cervix: the container
that could not hold her properly and that therefore could not help her
to get born in the usual way. This applied to the analysis as well. Each
of her external near-catastrophes—her near job loss, her drug use, her
near physical jeopardy in the nightclub situations—had the potential
to lead to a "death" of the analysis such that she would not be able
to continue to give birth to a real self on her own timetable.

On further reflection, it also seemed to me significant that in the
dream her mother had dropped off the birthday gift and then went
away. No mother remained present. I think this was the case with Ms.
A's actual mother. She provided my patient with physical life, but not
with a psychological birth. She did not remain an "in contact" mother
who helped my patient to grow and develop emotionally. As a
consequence, my patient suffered a great deal in her life. Things
educational, not toys, were important. Thus, no mothering contact
was made with the infant self on a level that was meaningful to the baby.

I believe that at this point in the treatment I was also this "drop
off" mother. Perhaps without understanding my patient's precarious
infancy, I was giving an "intellectual" understanding (things educa-
tional) to her but was not making genuine emotional contact (the
children's toys) in a meaningful way that could help her to be fully
present in life as well as in her analysis. My interpretations may have
also felt to her as if I were trying to lift or pull her out in some way
before she was ready. This could be experienced as a "brush with
abusiveness," similar to her experience with her prior night's sleeping
partner. In whatever way, the treatment seemed to be a "nearly
experience: neither fully life nor fully death.

Following an analysis of this particular material, Ms. A's "life and
death" acting out began to decrease. She stopped going to the night-
clubs and having encounters with abusive men rather immediately.
She also stopped taking mood-elevating drugs and I lost the feeling
that her actual physal well-being was in jeopardy. Much more
gradually, she began to get her work assignments completed in a
timely fashion. Further interpretations addressed, among other factors,
her rage at parental failures to "know her" and to bring to her what
she needed mentally in a timely way. I addressed this on a rather
continuous basis when she seemed to be moving into a "blue state" so
to speak. I also took up the possibility that at such times I might not
be in contact with her. She never again, however, returned to the near-
death enactments that were occurring regularly prior to the interpreta-
tion of her birth situation, its living out in her life and in the trans-
ference. I stopped holding my breath. The treatment that followed
involved a deepening of the understanding of the emotional impover-
ishment she had experienced from her mother and of her father's
complete inability to "see her" as a person. Over time she made
significant advances in her career and also developed more sustained
relationships with men.

There appear to be several possible explanations for the difficulties
of her actual birth experience. If oxygen deprivation did occur, then
the most likely possibility was a prolapse of the umbilical cord caused
by one of the baby's limbs pressing on the cord or the cord com-
pressed between the limb of the fetus and the uterine wall. Temporary
fetal distress ensues, leading to a reduction of the oxygen supply. Thus
the blue color. We speculate here because what actually happened is
not known. A significant shift occurred in the patient's acting out
however. Such a response would suggest that, in fact, something of the
actual situation had been addressed in the interpretation. Since my
understanding of this situation in the transference seemed meaningful,
I think that the mother's merely dropping off the gift may have been
precisely the reason that the birth situation was still so alive for this
patient. The center of the problem was the failure to hold. My patient's
manner of relating in the world might have been quite different had
her mother presented her with the gift of life, however precariously,
and then stayed with her emotionally to develop it. Perhaps under
these conditions, the birth situation would indeed have been registered
in her unconscious as only what it was: a temporary insufficiency
having no lasting effect. We would not have seen the derivatives of it
in many of her later behaviors or in the transference. With no
human object emotionally present to modify the distress, what was
really a transient experience at the beginning of life became a "way of
life" informing all of her development.

Clinical Example #2: A Physical Trauma in the Neonatal Period

Ms. B was a 49-year-old woman coming to treatment because of her
desire to be a successful musical composer and her inability to do so.
She was the youngest of three children, having one older sister and
brother. She described her mother as a distant, emotionally flattened person, unaware of and out of tune with her children’s feelings. The father was described as an angry man whose outbursts terrified my patient. All three siblings had significant emotional problems. Both the patient’s siblings were now married with families, although both had abusive spouses. My patient had never married but had had a series of relationships with very chaotic men who were emotionally unavailable to her.

Ms. B’s complaints centered on her difficulties advancing in her career and her inability to form a meaningful relationship. She wrote commercial tunes for a living and gave music lessons to children. She had a background of classical training and at times had been given assignments to assist in writing scores for television and minor film productions. She would, however, become too anxious to finish the assignments, and other assistants were called in to complete production. When she had an assignment other than to write a brief commercial jingle, she would come home in the evening, begin her composition, and then smoke marijuana to ease her anxiety. She would then fall asleep, getting nothing accomplished.

In the first month of treatment Ms. B spoke briefly of her birth situation. She had been informed at an early age that she had been born with Incomplete Acquired Intestinal Obstruction, that is, a blockage in the intestines that prohibited food from passing beyond a certain point. Digestion could not take place. Projectile vomiting of all nourishment would ensue. Emergency surgery was performed when she was a little over a month old to repair the problem, thus saving her life.

Two symptoms were particularly evident at the time of the dream that followed within the first six months of analytic treatment. The first involved the patient’s difficulty taking on and completing major assignments. The second and related symptom involved Ms. B’s anxiety each time she was offered an opportunity to take some steps forward in terms of establishing her career. She was noted by many to have a gift for her work, and from time to time she would be offered various possibilities that would open up new avenues. At these times, as she drove toward the particular audition that had the potential to advance her career, she would have frightening fantasies. For example, she would imagine having a serious car accident in which the cars would crash with such force that the abdomens of the passengers would be crushed. At other times the fantasy would be that an overhead freeway bridge would fall down on her, collapsing her car and crushing her chest and abdomen. She would have to get off the freeway and stop the car because the anxiety of impending catastrophe would become so acute that she could not continue to drive. During one session, while describing a recent anxiety attack as she drove to an interview, she reported the following dream:

_Somebody was saying to me, “Everything is in your head.”_

She had no idea of the location or circumstances of the dream or who was saying this to her, but she took this statement to mean, “All the problems are in your mind; they’re not really issues, but the problems you make of them in your neurosis.” For example, she explained that a recent large musical composition assignment was making her so anxious that she was now drugging herself with pills and marijuana in order to sleep at night.

I told her that one important rule by which dreams (the unconscious) operate is that they never take up what we already consciously know. They take up only what is truly unknown—what we are truly out of touch with. We already knew that some of the problems were “in her head,” so to speak, a result of her neurosis. So there must be some other meaning to this dream. She had no further associations. I was particularly struck with the emphasis on all: “It is all in your head,” meaning “exclusively” in her head, not located anywhere else. Perhaps the dream work involved a reversal: it was all located somewhere else besides the head. But where? I recalled that “it’s all in your head” was often used in common parlance (the patient herself used it frequently) to suggest that some pain in the body doesn’t really exist but is only a product of one’s imagination—“It’s all in your head; you don’t really have something wrong in your body.”

My patient’s infancy immediately came to mind. I said to her that all her problems at the beginning of her life had been in her body. In fact, she had almost died because her body’s digestive system was unable to function properly. A baby, I said, does not know the difference between its mind and its body; it just knows that, when it can’t digest, when it is starving from lack of nourishment, when it has a large incision made in surgery and various invasive procedures in the first month of life, it is in pain, and it feels the pain all over.

Ms. B had a stunning reaction to this interpretation. What came to her mind (and she did not know why it came to mind) was that she had had tremendous difficulties reading anything of any length all through her childhood to the present. Although she did extraordinarily well in high school and college, it was a very laborious process. She would mark off a small number of pages between book marks and would work laboriously to get through the pages at one sitting. She
would then have to take a rest before going on to the next small
grouping. She did not know why she had never mentioned this
problem to me before; it just never had come to mind. She went on to
recall how she did everything in very small amounts. Her jingles were
very brief, like the few pages between the markers. She would also eat
very small amounts at any one sitting. Her various boyfriends usually
complained about the length of meals because of her need to stop and
pause between each few bites of food. She then remembered that her
mother had told her that she had had to be fed by an eye-dropper as
an infant because she had such tremendous difficulty digesting
anything in quantity.

I suggested that perhaps she was also telling me that she had so
much trouble digesting that she could take in only a tiny bit of
interpretation at any given time. Then we had to rest before she could
take in the next small amount, only an eye-dropper full at any given
point. She said that she worried that I, like her boyfriends, might wish
to complain about the slow pace.

She then proceeded to tell me more about what she knew of her
early trauma. Her mother's pregnancy and delivery were normal, but
the baby had increasing problems almost from the moment of birth.
Her difficulties in digesting led to more and more weight loss until
she was literally in a condition of starvation. At first it was not clear
what was wrong. Her mother told the patient that she (the mother)
did not seem to be aware of the seriousness of the baby's condition.
She thought that all babies cry often and often have difficulty
adjusting to formula. Thus, her baby's continuous spitting up and
eventual projectile vomiting did not, at least initially, seem out of the
ordinary. Ms. B's mother had lost her own mother early in her life.
She thought that it was important to raise the baby without any help,
as she had had to do everything else as a young girl without any help
from a mother. She therefore did not call the doctor when problems
were evident. Finally, at the end of the baby's first month of life, Ms.
B's mother went to the pediatrician in some alarm. The physician
recognized a serious problem immediately and rushed the baby into
surgery. The problem was repaired when the baby was in a completely
deteriorated condition. After the repair, my patient developed
normally physically. She was, in fact, extremely bright and capable,
although she became an inhibited child with many fears.

The material concerning her disaster fantasies when going to
events that would open up new opportunities in her career was taken
up in this hour as well. Each new opportunity for advancement stood
for a metaphorical "birth." To be born in any kind of way meant to

have to reexperience the disaster of her infancy: starvation, pain,
surgery, and near-death. These, then, were the disasters she fantasized,
the panic attacks each time she headed for something new and
creative. The crushing of the abdomen and chest that she fantasized
must have been analogous to the real experience of the crushing
spasms and pressure in her stomach and esophagus when she was
unable to digest and projectively vomited. She must have felt with her
"baby feelings" as if she were dying. Ms. B cried at this point and
could say nothing. I commented that essentially, all these years, she
had had to stay in a state of being "unborn" just in order to survive.
This meant that we could not have a psychological birth here in her
analysis, nor could she have a birth of any major sort in terms of her
life. Such a "birth" would only mean that a disaster would follow.

We had known about and discussed Ms. B's intestinal obstruction
a number of times during the treatment prior to this dream, but it was
only at the time of the dream that the material regarding her difficul-
ties in doing anything in depth and breadth—anything that would
lead to growth—could be understood. It was connected to her infancy,
to her very traumatic beginnings.

The following hour, Ms. B reported a dream that she was lying in
her bed and awoke gurgling, nearly choking. She recalled descrip-
tions that her mother had given her of her digestive problems. I wondered
aloud if perhaps I had not fed her too much the hour before—more
than an eye-dropper full. The patient said that she thought that was
a possibility but that she had found the understandings very important
and had felt these "baby feelings" the entire day. I suggested that
perhaps the dream was saying that she was still living in the state of
mind of the precocious infant who had nearly choked to death and
could not digest. Her ill baby-self had never gone away. I later
speculated out loud that perhaps her drug use was also connected to
this problem. Drugs were her only means to block out awareness. She
would put herself to sleep, as she must have tried to do as an infant,
so as not to be aware that she was in pain, starving, and dying. Ms. B
recalled many years of childhood sleep difficulties and nightmares.

I proceeded to deal with the transference in more depth. I noted
that when I did not understand these terrible problems, so fundamen-
tal to her very existence, I must have seemed to her like her unaware,
flattened mother, a mother, as she experienced it, completely out of
touch, who would just let her starve. Perhaps, then, I was the person
saying, "It's all in your head." Ms. B had indeed spent many treatment
hours describing her experience of her mother as completely lacking
in warmth, emotional holding, and concern. That kind of relationship
must have left her feeling all alone, filled with anxiety and terror. In my lack of understanding of her terrifying infancy, I must have seemed like this mother, saying, "Shape up. There's nothing wrong with you; you are just imagining it." How could she put herself to sleep in the face of such a lack of mothering? She could not. Marijuana and sleeping pills were not available to her as a baby; so she could only have anxieties, insomnia, and nightmares. If I was a similar kind of mother, she would feel anxiety here too and would have to try again to put herself to sleep. Two such mothers would be more than a baby could bear.

Ms. B stated that, although she did not consciously perceive me in this light, the understanding had brought to her a sense of calm. I noted that when I seem to understand I must become like her pediatrician, the "aware mother" who could provide holding and understanding and thus initiate the life-saving surgical repair.

Analysis of this early trauma seemed to alleviate some of Ms. B's symptoms. Her panic attacks on the freeway began to subside almost immediately after her infancy situation was understood. Her marijuana and drug use also diminished considerably, and she eventually gave up the use of drugs. Lengthy composition projects have remained difficult, though she did undertake and complete for the first time several major projects within the year and a half following these interpretations. This in itself was a significant accomplishment. She could not, however, do so without considerable anxiety. Her dynamics are complex and other factors are involved in this particular symptom, including her rage at and terror of her father and his seemingly unconscious wishes for her not to exist, let alone succeed. The work on her relation to her father continued for some time.

Clinical Example #3: A Long-Term Strain Trauma Beginning at Birth

Ms. C is 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 four and a half 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, I 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:

[Going back East]: I am going to the East in a couple of days for the divorce. 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 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. I don’t recall who stamped the paper 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 her 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 reside. 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 was she thinking unconsciously of prenatal classes and concerns with what went on in the womb at the time of the divorce? 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 that 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. Beyond the divorce, her mother’s traumatic death was still a 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, as well as her life: at her prenatal times. 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 experience, would become clear.

I thus took up the “story” 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 the story of 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 it has a mother like this begin to immunize itself 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 represented two things. 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 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 it, 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 I 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 in which her mother told her of her dislike for feeding and taking care of 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 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.

She did begin 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 her 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.

The 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 the 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, 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—as her dream’s “story,” which begins at her birth, tells us. Such an understanding is in line with the research findings of Terr (1988) and the psychoanalytic investigations of Bernstein and Blacher (1967), Schur (1966), Paul (1981), Dowling (1985), and Laibow (1986): 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.

I believe also that this dream is illustrative of the importance of ascertaining the specific associations to each element of the dream, at all times but particularly in cases of early trauma. Had I not inquired into the details of my patient’s relationship with her cousin, the “prenatal” story would not have unfolded. On the manifest content, the fact that she landed at a home of her cousin, who was having a party could sound like a flight from pain—she was going to a party to get away from the pain of the divorce, or some such understanding. The whole story was understood only because the prenatal detail was ascertained. The patient then confirmed the story in her associations to her birthday—which she had forgotten. It was now clear that the birthday and her terrible situation with her mother from infancy were the primary day residue. Her story would never have been properly understood without this crucial and unexpected, or “out of place,” association.

Finally, I feel that this dream is a very important illustration of the “compromise of the mind” that can happen when trauma involves hostile material projections into the infant (Ferenczi, 1932; Fairbairn, 1952; Kahn, 1964a; b; Bail, in Reiner, 1993a, b). Essentially she had to “leave her mind” (to erase it) perhaps, as suggested in the dream, from the very first moments of her life, in order to mute awareness of a parent 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 #4: Sexual Molestation in Infancy

Ms. D, a 47-year-old waitress, came for marital therapy with her husband because of a stormy marriage of several years. Both had prior marriages and several children between them but no children of their own. There was much conflict and resentment regarding each other’s treatment of the children as well as quite a bit of tension in the sexual relationship, which they did not specify initially. I was just beginning to get some idea of the history of the couple’s marriage and their individual childhood histories when an event occurred just prior to the fourth session of the couple’s treatment. Ms. D had been working in the restaurant where she had been employed for the past two years when a customer, obviously having had too much to drink, became quite seductive with her. While getting up to pay the bill, he fondled her on the buttock quickly, sliding his finger near her anal area. Ms. D was taken aback by her intense response to his behavior, since customers had on one or two occasions harassed her before (kissed her or stroked her breast). She had not reacted so intensely at those times. She now found herself very agitated, had some difficulty concentrating, and kept repeating the event in her mind. She had always had sleep difficulties, but since the day of the incident, getting to sleep had become a considerable problem.

When she initially came to marital therapy she seemed most uninterested in talking about her early history. She wanted to focus only on her husband, so that it was difficult to get a picture of her in time and space. She became more open to discussing her childhood only as she felt the need to understand her intense response to the experience in the restaurant.

Ms. D was the youngest of three children, with two older brothers. Her parents had divorced when she was in her teens, although they had had a very conflicted relationship throughout. My patient had been a very withdrawn, timid, and frightened child. She remembered fears of strangers, particularly men, coming in the home. She would cling to her mother. She had a fear of taking baths. She did not know why. She became sexually precocious and more outgoing as she grew.
She recalled attempts to tie her dolls in ropes and place them in bondage positions. In grammar school she was preoccupied with the genitals of animals and would draw pictures of animals with huge genitals. She recalled becoming sexually consumed as an adolescent. She slept with many boys indiscriminately. At one party, she danced naked in front of boys. In her early 20s, she became a topless dancer in Las Vegas for a period of time. She quit, however, feeling the life style was too lonely and abusive.

Since Ms. D’s particular distress had been precipitated by the customer's contact with her buttock, I asked if she recalled any early issues in this specific regard. She said that she had been particularly preoccupied with having anal sex as far back as she could remember. In fact, this was an issue in the marital relationship. Her husband did not enjoy anal sex, and she experienced his withholding from her as withholding and a lack of caring. She then recalled that she had recurrent intermittent proctitis, a physical condition involving recurrent rectal infection. The condition occurs, she was told, when one has had some damage to the mucous within the rectal wall, often due to old scarring. She had been informed during one physical exam when she was in her 20s that she had traces of scars—really a series of faint diagonal lines or discolorations—in the upper inner thigh area. The doctor had asked her if someone had dug fingernails into her skin.

Ms. D stated that her mother had suggested at one time, in a fit of rage at her father, that her father may have molested her as a very young girl. The father would encourage the mother to take the boys on errands and would offer to baby-sit his daughter. Ms. D had no conscious recollection of molestation.

In the marital session following the incident in the restaurant, Ms. D reported the following dream.

I was in the room where I did my topless dancing in Las Vegas. My (at the time) large black boss was there. The room that I danced in was completely dark. There were no tables. Instead of a whole large audience, there were 10 or 12 men sitting around the dance area. There were wooden bars around the whole area. I went to get my records to play in order to do my particular solo dance, but they were stolen. There was no name and no identification in the slots where the records were kept. If I couldn't get the records, I couldn't dance.

Ms. D's associations to the dream were:

I did topless dancing for several years in Las Vegas, as I had mentioned. Men would sometimes get abusive. I was very young and found it difficult to be away from home in a cold and competitive environment. My boss was rather cruel. He would get very angry if I didn’t do things just his way. He reminded me of my father in that way. He intimidated me. The rooms I danced in for the shows were dark, but this room was smaller, had no lights on at all and no furniture around except the chairs the men were sitting in. Usually they serve drinks and food on the tables in Las Vegas. The room doesn’t seem familiar. I never saw a room with wooden bars before. Maybe it was like a prison, but I have no experience of prisons except what I have seen on TV. Usually there are audiences full of men and women during the shows. This was exclusively men and only a dozen or so: a very different feeling than the Las Vegas shows with hundreds of people in very large rooms. I used to use particular records when I did my solo dance. I don't recall now what songs were involved or which ones were in the dream. In the dream, it was just that they were stolen. I didn’t know who stole them. That never happened in real life. I was never robbed in real life. I had a mailbox with my name on it in the hotel where I danced—but these slots were on a slant in the dream. I don’t know what that means. My name was no longer there and the records were gone.

I said that it seemed significant that she had had many sexual experiences, preoccupations, and activities in her life and yet it was this one incident—the fondling of her buttock—that had caused her to feel traumatized. I noted that some of her symptoms were those of a traumatized person (i.e., her lack of concentration, sleep disturbance, recurring thoughts of the experience) and that because of this, I had to think that this brief experience stood for something very important. I said that her lifelong interest in anal sex, her preoccupation with the genitals of animals, her doll play, her choice of occupation as a young woman, all spoke of a mind and body that had been somehow filled with experiences with which it simply could not cope. I told her that, from her dream, I suspected that such experiences went back to her earliest years—or at least that she felt these experiences from the perspective of a frightened infant. I told her that I did not know if my understanding of this was correct, but that I thought we needed to
address the possibility and see if this understanding resonated with her in any way. She said that she wished to hear my understanding.

I suggested that if we follow the dream the scene might be an image of her experience, or how she perceived her experience, as an infant. The room with no furniture, dark, with wooden bars, would be a nighttime view of her bedroom from inside a crib. This was perhaps a scene in which her father (or some man) came to her room in the night (the large black man). He was large and black because in the night, to a baby, adults are large and dark. The 10 or 12 men would stand for the fact that this type of experience had happened many times over. What she might be saying was that the experience of repeated abuse as an infant led to the loss of her identity. In other words, there were no records; her name was gone. The identity of who she could have been was stolen from her by this experience. In this sense, I said, if this understanding was correct, then she really had been robbed—robbed of her infancy, robbed of a chance for her own mind, her own body, her own personality. Her infancy, her crib, was a prison.

My patient appeared stunned, almost dazed for a time. She suddenly remembered that the slots where the records were supposed to have been kept in the dream were exactly the size and number of the diagonal marks on her inner thigh. She began to cry profusely. Images came to mind of her sexual preoccupations, her sexual fantasies as a topless dancer, how she wanted to please her father by acquiescing to his demands for her to be with him: "He seemed to be touching me always."

The next week, the patient came to her marital session looking so different that I almost did not recognize her in the waiting room. Her face seemed younger and much less strained. Her eyes were bright and clear. Her previously unkempt hair was combed and neat. Her clothing was much less tight-fitting and seductive. Ms. D announced that this was the first week in her entire remembered life that she had been able to sleep through the night, and to do so without the light on.

I saw Mr. and Ms. D for only a couple of months of marital sessions. It was clear that they were both in need of more intensive individual analytic treatment and that the marital work had helped them to recognize this need. I referred them each to different analysts, and they began their individual work. Ms. D did report, however, that during the course of marital work her preoccupation with anal sex seemed to have diminished as had the other symptoms following the incident in the restaurant. She was sleeping better on a regular basis, and the tension in the marital situation had also decreased to some extent. There was much work left to be done in all areas, however.

**Clinical Example #5: An "Environmental Trauma" at Birth**

Mr. E is 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 unsuccessful 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, which 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. My patient's struggles to find himself, to utilize his many talents, and to have meaningful relationships with others clearly were related to the problems involved.

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 which in the dream looked almost like a trench, very long and narrow. But this trench had glass around it like a greenhouse (holothune). 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 that 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 same-age best friend, 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 represent also the incubator with its glass 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 three weeks. Instead, he was taken care of by a single nurse in the nursery. His mother pumped breast milk, which he was fed from a bottle 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 pursued normal development.

I suggested that perhaps we could understand the devastation (the war ravages in his dream) in the light of this experience. They would be the effects of the “natural disaster” in the dream, the jaundice and diarrhea epidemic in the hospital. I felt that he had identified with his best friend, a bright and talented, 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 in 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 by his aunt, who was not able to make contact with him for almost three 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 that this might be the feeling that he had not been able to put into words.

I said that I thought that this was the issue currently in our relationship as well—the fact that he felt that 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 his 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 three 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 his 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 an 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. Shortly after this interpretation, however, he was able to begin to exercise and take long walks in his neighborhood. His complaint about my impersonal manner and his inability to make contact with me emotionally began to dissipate at this time.

Exactly on his birthday one 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 that 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 his “marginal state.”

By his birthday 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 separating from 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 Terr (1991) and Lipin (1955): 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 (as opposed to the dream) is the primary vehicle for analytic work (Gill, 1982; Caper’s discussion of Freud, 1988). The dream material of my patient, however, 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, then, and my patient, were both reached through the dream.
Clinical Example #6: The Trauma of a Premature Birth

Mr. F was a 19-year-old young man who came to treatment because he could not find any interest, goals, or direction in life. He described himself as suffering 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. He was the second of two children, with an older sister. His parents had had a difficult marriage and divorced during his patient’s early teens. He 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 six 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 youmade 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 history 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 nor to the exit in which the front of his car was smashed but he was not hurt. He noted that he had 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 association to the man saying that he was lucky that he made it and 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 history teacher, she seemed to be a very kind and capable woman who would not be likely to be fired. He found history an interesting subject. His particular history teacher, he said, organizes and manages all 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’s whom he had known all of his life. She had cared for him when he was a baby.

Like the patient, I too was puzzled by this dream. Certainly the bare feet and 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: coming out in 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 dreams. If the front end was smashed, then perhaps Mr. F was making reference to a specific and concrete experience in this 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 incomplete.

Thus, I suggested, after trying other possibilities, this dream might relate to his birth (about which I knew nothing at the time) because of the form of his 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 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 incurred 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 and been told by her doctor that it was very unlikely that 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’s. I told the patient that this must be a reference to the teacher who was fired—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 and 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, and teaching 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 then the baby was induced because it would have been poisoned by the Rh complications in another 72 hours 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 hold him. Perhaps, I said, the dream was expressing his feeling 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 last 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, and he could not have managed the ordinary tasks of life. Certainly school, chores, relating to friends, and so on would be 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 occupied 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 two-and-a-half 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 be 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 #7: A Double Trauma at Birth and in Infancy

Mr. G, a 29-year-old man, came to analysis because of many unresolved feelings regarding his early childhood experiences. He saw himself as a withdrawn and closed person with an underlying feeling of embarrassment and humiliation about himself. He was chronically irritable and angry and felt needful much of the time. He indulged in some mild drug use on a regular basis. He had difficulties settling on and developing a career and establishing himself in a meaningful relationship some years after a divorce.

The patient was one of three children, with two older brothers. The issues surrounding his beginnings in life were very traumatic. His father had just finished law school at the time of the mother’s pregnancy with the patient, and the family was moving from their home in the Southwest to Los Angeles, where the father had obtained a job in a prestigious law firm. Mr. G’s mother moved to Los Angeles with the older siblings to set up house while the father was finalizing arrangements for the move. But at this point the father had an acute psychotic break and suddenly killed himself. This suicide seemed to happen, as far as the patient could gather, “out of the blue.” My patient’s mother, six months pregnant with him at the time, was overwhelmed with the sudden and completely unexpected loss of her husband and remained medicated and sedated for the last three months of her pregnancy. Mr. G was informed over the years that he had been a very difficult baby, crying constantly, and was described by his mother as “inconsolable” from the time of his birth.

Following the father’s death, the mother moved into her parents’ home, where she stayed with her children until Mr. G was about four years old. Mr. G’s grandmother appears to have been a very troubled woman who was preoccupied with bowel functioning and apparently began giving the patient enemas regularly while the mother was at work, despite the mother’s request that she not do so. The patient felt that the enemas were administered until he was almost three years old, when his mother was able to persuade the grandmother to cease the practice. The patient had no conscious recollection of the enemas but only memories of feeling very withdrawn and frightened and of retreating to his room in a “state of shock” following what he later learned were the enema experiences. This “later learning” of the enema episodes came about sometime before he began his analysis after seeing a film about a woman with a multiple personality who had been given repeated enemas by her psychotic mother. Mr. G had a very severe panic attack while viewing the film; he became overwhelmed, shaky, and frightened during the enema scenes. Inasmuch as he had never had panic attacks before, he discussed the situation with his mother, who then informed him of his early experiences with the grandmother.

Early in the analysis, the patient had a dream of a horse kneeling on a white cloth. The location of this scene was not clear. He could only see the horse and the cloth, and the “camera angle” of it seemed to focus progressively in on the kneeling knees of the horse. The dream appeared to represent his own position as a baby kneeling for the enemas, the white cloth standing for the diaper. It seemed as if he had been metaphorically “brought to his knees” on the diaper in shame, humiliation, and rage as he was subjected to the intrusive and traumatic procedures. Initially, the analysis, in which the patient would lie down and interpretations were made from behind his head, was experienced as a similar “get on your knees” intrusive predicament.

The patient’s birthday occurred several months into the treatment, and he had the following dream:

I was in the forest with my brothers and my older cousin, Allan and his wife, Rebecca. They had brought some trinkets from a trip they had been on which they were giving to my brothers and myself—one of which was my birthstone. The second gift was a wood contraption or structure of sorts in which a bear came out, looked around, made a funny noise—a cry or a grouchy sound, and quickly went back into the structure.

His associations were:

The structure itself around the bear was very old, rough wood, clearly neglected, clearly not kept up. It reminded me of some of those toys or clocks in which the toy comes out, makes a noise, and quickly goes back. Only this wasn’t kept up like a nice shiny toy or like Disneyland where they have these things made to look old but they are kept up very well. This was truly neglected and worn. The bear itself did not seem neglected and worn, just the casing out of which the bear came. Allan and Rebecca, my cousins, are a very nice couple. Of my whole family, they are probably the most congenial and
the ones that I would wish to keep contact with. It was as if they were the parents who go on a trip and bring back presents for their children. I always looked forward to that when my mother or grandparents did that on occasion. My birthstone must connect to the fact that it’s my birthday. I have always thought of the forest as a nice place to be, quiet and peaceful with nature all around. The bear toy was supposed to be a novelty they found. The scene reminds me of a fairy tale when you’re in the woods and there’s the bears and animals, except that the casing of this toy bear was so worn. The bear just made a grumpy noise—as you think of bears when they make their noises. We were amused in the dream, but I had the feeling that despite the amusement, it was somehow a very serious thing. Real bears scare me but this was a toy and it did not.

I said that I agreed that the dream might be saying something about his birth, since it was his birthday today and one of the gifts brought to him in the dream was his birthstone. Perhaps the quiet peaceful forest was his mother’s womb or body. The couple might stand for his parents, but his parents at an earlier, better time—perhaps at the time he was conceived rather than the time when he was actually born. He might be saying that when he was conceived, he was meant to be like the gift or jewel that was given to him. Mr G said that his mother had told him that he had been a planned and wanted child. He began to cry.

I said that perhaps the very worn, neglected case in which the bear came out stood for his mother, worn down by her trauma and grief, no longer well and not equipped for the birth of a new baby all ready for life. His mother had told him that she had given up at the delivery, that she had gotten to a place in the process in which she could not do any more and they had to extract him with forceps. “My mother said she had nothing left to work with. She was so exhausted from her grief and the emotional pain she was in.” I said that he must have felt, in an “infant way,” these awful feelings. Perhaps we could say that he came out like the bear, looked around, saw the terrible circumstances, and could only make a grumpy sound (he was told that he was a grumpy, irritable baby) and psychologically go back inside. At least inside, he would feel more peaceful and tranquil, like the forest. Perhaps he worried that if he remained outside, he could not be cared for by his mother or would wind up becoming worn and neglected just like her.

The old casing reminded Mr. G of his mother’s old robe and messy hair on Sundays, when she would sit for hours, depressed, with the curtains drawn, and would sleep on and off all day long. She too would come out for a moment and then go back inside to her room and to oblivion.

I said that he seemed to still be in this “inside,” unborn state and that our problem was how to get him born in his life and in the analysis. He also needed to know, I thought, that I would not be like his exhausted and worn mother, who had given up; rather I would be able to see him through and give him psychological life in a natural way.

The next day Mr. G arrived 10 minutes late (unusual for him) and presented a dream in which he was erasing a cassette tape at the same time that he was saying “Wait, stop, let me see it.” He said that he used cassette tapes to record many aspects of his current projects at work. He imagined that the two contrasting states represented his mixed feelings about what we had discussed the day before, his birth. He wanted to erase it and at the same time he wanted to know about it. He went on to say that he had felt very sad and thought that perhaps he didn’t want to be born again. I commented that perhaps he couldn’t imagine that things could be different from what they had been at the time of his original birth.

He said, “I think things could be different if we could sort out the different factors; but there seems to be a big X over it, as if I’m not supposed to go over it in my mind.” I asked why that would be so. He answered, “I always thought that day was one of the saddest days in the world because my father was not there. There was no joy, just get it over with. I was a complication. My mother couldn’t attend to me at all. There are no baby pictures of me whatsoever, no baby books, only of my older brothers. My mother needed so much care herself after my father’s death. I thought she didn’t like me.” I said that such an impression must have been the only thing he could make of it at the time, the only way he could comprehend why she was so unable to care for him.

I asked about the tape erasure and his feeling that he was not to go over the birth in his mind. He said, “It was a secret. We were not supposed to talk about it—about my father’s illness and his death. It was, in fact, never talked about in the family.” I said that his response to my question indicated that he had gotten his father’s death and his own birth mixed up together in his mind. He said, “Yes, I tied with that from the beginning; I think it was just too close. He left; I came. Everything changed. Nothing was the same as it was before.
They never talked about him and never talked about those days, never. It was a taboo subject.”

I said, “It would be difficult for you to come here because you are not supposed to talk about your father’s death, and you and your father’s death are treated as one. So you are not to talk about yourself either. The two things are fused in your mind and shrouded in secrecy and embarrassment.”

He said, “Well, that’s the way I’ve always felt, totally embarrassed about my birth and my existence. I do think that way. I have these things connected. I can never think of one without the other. Everyone said, ‘He died and then you were born’ in the same sentence with the ‘and’ connecting them. I thought that at times that his dying may have allowed me to be born. Why was I living and not him? Maybe he was angry about this. Certainly, my brothers were mad. They no longer had a father—they just had me.”

I said that there must have been so many fantasies and so much confusion for a little person to cope with when nobody would talk about it and help him to sort it out. He said, “I don’t want to think about him very much or to think about this. They said, ‘Don’t ask about it.’ But I guess part of me wants to know because in the dream, I say, ‘Wait let me see it.”’

I said that the part of him that was erasing the tape was identified with the family, whom he saw as wanting his birth and his father’s death erased. The part that was saying “Wait, stop, let me see it” was the part of him that was identified with me and the analysis and therefore wanted to be born and wanted to know about himself and his beginnings. He agreed.

I suggested that perhaps he thought that, if we could understand this, maybe we could put his birth and his father’s death into two separate sentences with a period between them, so to speak. Then, he could exist without the shame, embarrassment, and secrecy that surrounded his father’s death. He could come out to life and not have to go back inside. He thought that if we could accomplish this, it would be a very good idea.

Now, several years into the analysis, Mr. G describes himself as feeling much less angry and “grouchy” and much more interested in people. He has stopped his drug use. His feelings of shame and humiliation have not been a topic of the analysis for quite some time. He has worked very hard to situate himself in an established and professional career for the first time. This particular goal seems to him to be a truly important achievement in his life and his analysis thus far. He continues to work on the meanings of his mother’s emotional absence from him for many of his early years and the loss of the father he never knew.

Perhaps it would be useful to mention an incident that happened with Mr. G’s drug use because it illustrated so well how important it is to obtain specific associations to the dream elements. With birth dreams, it appears that associations are not always readily forthcoming (see Pulver, 1987; Williams, 1987). The form of the dream and the symbolism—such as here the forest for the mother’s womb, or, in Ms. D’s case, the crib for the wooden bars, along with the day residue and the history—bring one to a working hypothesis about the birth or infant experience. Sometimes, however, the symbolism can be misleading.

At one point in his treatment, Mr. G decided to stop using recreational drugs, which he was then taking in small amounts on a nightly basis. He was in the initial weeks of withdrawal, a very uncomfortable time. He had a dream in which his puppy was being strangled by a rope and was drowning in a pool of water. Mr. G himself wondered if this dream was about his birth—if the rope stood for the umbilical cord strangling him at the time of his birth. There was, however, no evidence that such a thing had happened and no reason for his birth to come up as the day residue at this particular time. I asked Mr. G if he had any associations to his neck and the strangling. He recalled that the day before he had been to his doctor, who had told him that all Mr. G’s feelings seemed to be located in his neck. The meaning of the dream, as it turned out, centered on Mr. G’s being strangled with and drowning in all his feelings now that the drugs he had relied on for so many years could not be used to suppress them. He was completely filled with his feelings, not with his birth. Such are the interpretive pitfalls.

Clinical Example #8: A “Change-of-State” Dream
Following a Ten-Year Analysis

This last example is a dream that appeared in a patient after 10 years of a complex and difficult analysis. This patient, Mr. H, is a 45-year-old man who came to analysis because of his despair about his second failed marriage, the failure of other friendships, and career struggles. He was extremely depressed. He was totally preoccupied with the failure of his marriage and his wife’s abandonment of him. The situation so consumed him that he found it difficult to think or to work. He had always been a lonely person, finding it difficult to make
and retain friendships. He was, nevertheless, not without warmth and generosity despite an overall significant disturbance. Despite having some talent for his work, he seemed to have a great deal of difficulty sustaining his business and holding the various jobs that he acquired over the years; thus he was always “living on the line” and just “barely making it."

The patient was the only child of his parents but had three older half-siblings from the mother’s first marriage. The mother was a very narcissistic woman who had been deprived in childhood and used her children essentially as mothers for herself. Mr. H seemed to live, as illustrated in one dream in which he was holding a compact of eye shadow, as literally “the shadow to his mother’s I (eye).”

He was a planned child. The parents had been married a number of years and the father had expressed an interest in having a child. The mother had not planned on more children, since she had three nearly grown children, but she acquiesced as a gesture of appreciation for her husband’s loving care of her and her three children.

Mr. H was told of his precarious beginnings by both parents at different times. As her pregnancy was described to him, the mother experienced extreme morning sickness for five months; it lasted from morning until night and incapacitated her completely. She vomited constantly, lost a great deal of weight, and had a difficult time leaving her bed. The father apparently felt very guilty about his wife’s suffering and suggested an abortion. In fact, he took her to an abortionist and the procedure was initiated. But just as the instruments were about to be inserted into her, his mother asked that the procedure be stopped. She was a compulsively clean woman, according to the patient, and told the father that the instruments in the setting seemed too dirty. She could not go through with it. The father took her home, and she completed the pregnancy without complication. Delivery and the neonatal period were normal. The baby was extremely distressed in his early months, suffering severe colic and crying continuously. The mother was quite anxious about caring for this child, who had been born to her late in life. Nevertheless, she described this to the patient as a very happy time—that she and his father were actually thrilled with having the child. The patient’s physical development progressed well, but he appeared to have been a lonely, depressed, and extremely anxious child who had a great deal of difficulty relating to other children.

There was certainly evidence in his unconscious that, despite the mother’s protestations otherwise, he was less than truly wanted by her. In the dream presented in his first consultation hour, Mr. H is seated on a grassy hill in a lovely picnic area. A beautiful actress comes toward him. He thinks that she is there to join him for the picnic, but instead she comes to choke him to death. In association, the actress closely resembled his mother. He had been born, expecting a pleasurable, feeding experience (a picnic); instead the attempt was to murder him. He should not exist. He was worried, of course, that he would come to analysis and have the same experience with me. The possibility of new life could only bring a wish on someone’s part for his death.

The overriding theme of his analysis was what I would describe as “his precarious state.” This was particularly evident in his financial and work situation. Each time he began to do well in his business, things would suddenly and dramatically deteriorate so that he would be “on the edge” financially. His analysis would be in jeopardy. His living circumstances would be in jeopardy, and he would have to struggle to get various jobs just to survive. This pattern was repeated many times in his treatment, and, in fact, his existence, like that of the patient in example #1, was always in a state of “near sudden infant death.”

One illustrative dream occurred some years into his analysis. In it, he was at his linen closet reaching for something. At the front of the closet were baby toys and other infant paraphernalia. At the back of the closet were similar baby things. There was a large empty space in between. Mr. H’s associations to the empty space involved his having viewed a recent TV science program in which a particular empty space was described metaphorically as a very precarious state between life and death. I think Mr. H was saying that he had lived in such a state from the very beginning of his life, from the time of his infancy, if not from the time he was in the womb (hence the baby items) and this was being reflected in all his difficulties.

It would be impossible to describe here the entire course of a 10-year analysis. Suffice it to say that by the end of 10 years this patient had improved considerably in all areas of his life. He now had a number of enduring friendships. He had a very stable and caring relationship with a woman. His shaky finances and business had improved. His business had not only stabilized for a considerable period of time, but was now growing. In one analytic hour, Mr. H was noting his improvements and the contrast between the richness of his life now and the poverty of his beginnings 10 years earlier. He then reported the following dream.
I was getting married and I was very very happy about it. This seemed to be a much better relationship than the others. We were at the altar and the woman I was marrying had this dull gray metal ring on her finger from a prior marriage. It was important that we get the ring off to proceed with the ceremony. It was very difficult. We struggled. It seemed to be almost cemented to her finger. However, finally, the ring was removed and the ceremony proceeded. I was so extremely happy.

In his associations to this dream, Mr. H stated that he did not know the person he was marrying but hoped that it was a marriage to me, meaning that we were now having a good analytic marriage. He had no associations to the dull gray ring or to the place or circumstances of the wedding.

In associating, he kept repeating how thrilled he was about the marriage. What he meant to say in describing this feeling was, “I can’t believe this is happening; I can’t believe this is happening.” However, what he actually said was something slightly different. This difference led me to tell him that I did not think the person he was marrying was me; rather, I thought the person he was marrying was himself. He was surprised and asked how I had arrived at this understanding. In response, I asked him if he had noticed his slip of the tongue when describing how thrilled he was about the marriage. He said “No,” that he was not aware of any slip of the tongue. I told him that he had meant to say “I can’t believe this is happening.” Instead, his slip of the tongue was, “I can’t believe I am happening. I am so thrilled, I can’t believe I am happening.”

The patient gasped in shock. After a long pause, he said, “This means that I am happening—meaning that I can be born. I don’t have to be an aborted baby. I can have a life.” He began to cry and then suddenly recalled that the gray metal ring on the finger of the bride, the item to which he could bring no association, was exactly the way he had imagined the material of the abortion instruments—dull gray metal instruments that did not look clean. If this “abortion ring,” which appeared to be cemented to the bride’s finger, could be taken off, then he would not have to be the “almost aborted baby.” He would not have to live in the very marginal state in which he could not fully progress and grow. He could be born and live a full life. He could be born in the analysis as well.

Mr. H expressed through his tears that perhaps this was the point of it all—the point of the years of hard work of analysis—one could finally say, “I am happening.”

SUMMARY

Infant traumas, as reconstructed from dream material of eight analytic patients, ranged from physical and accidental environmental traumas at birth and infancy to traumas involving the projections of maternal hatreds and disturbances, that is, sexual and mental abuse. What does a baby do with such experiences? Evidence from this material suggests that the experiences “grow” with the baby, organizing and influencing later behavior, thoughts, fantasies, symptoms, and “ways of life.” Evidence from this material suggest that aspects of these traumas are lived out as if within a time warp. Life becomes the trauma, and trauma becomes one’s life.