Int. J. Prenatal and Perinatal Studies Vol. 4 (1992) No. 1/2, 17–33

Birth Memories, Birth Trauma, and Anxiety*

D. W. Winnicott

Abstract

Winnicott describes traumatic birth experience as a basic matrix of experience. He gives casuistic examples of actualisations of traumatic birth experiences in the therapeutic situation and deals with the perinatal roots of psychosomatic symptoms, especially headache, breath disturbances, sensations of constriction in the chest, and so on. He demands, that in cases of persecutory anxieties it is necessary for healing to reexperience the traumatic birth condition in the analytic situation.

Zusammenfassung

Winnicott beschreibt die traumatische Geburtserfahrung als ein Grundmuster für das spätere Erleben. Er gibt kasuistische Beispiele für die Aktualisierungen traumatischer Geburtserfahrungen in der therapeutischen Situation. Er behandelt die perinatalen Wurzeln psychosomatischer Symptome, speziell Kopfschmerz, Störungen der Atmung, Engegefühle im Bereich der Brust usw. Er fordert, daß bei Vorliegen von Verfolgungsängsten die zugrundeliegende traumatische Geburtserfahrung in der psychoanalytischen Situation unmittelbar wieder erlebt werden muß, um eine Heilung zu erreichen.

In this paper I wish to present certain clinical examples illustrating fantasies and possible memories of the birth experience.

In psycho-analytic theory there has been some confusion since Freud put forward the valueable idea that the symptomatology of anxiety may be related to birth trauma. It is not clear whether birth memories are individual or racial, whether birth can be normal or whether trauma is an inherent part of birth or a variable and chance accompaniment. Also, what exactly is the nature of the

* Paper read before the British Psycho-Analytical Society, 18th May, 1949. It was published as Chapter XIV in *Collected Papers*, Basic Books, New York, 1958.
Abstract was added by L. Janus. It is now reprinted, because it is basically important and very unknown.

trauma in terms of ego psychology? There is therefore much left over for research, and perhaps the following collection of ideas may be useful in stimulating thought.

It is difficult to know how to quote Freud usefully at this point. To do Freud justice one would have to write a separate paper tracing the changes in his views on the relationship between anxiety and birth trauma. This would be an excellent exercise and it has already been done, notably by Greenacre.[1] In any case it is not necessary for me to try to do justice to Freud's views here. On re-reading many of his references to the subject since writing the main part of my paper, I think I can find everything that I have suggested somewhere in his writings. Perhaps I could best quote the sentence where he says: 'Now it would be very satisfactory if anxiety, as a symbol of separation, were to be repeated on every subsequent occasion on which a separation took place, but unfortunately we are prevented from making use of this correlation by the fact that birth is not experienced subjectively as a separation from the mother, since the foetus, being a completely narcissistic creature, is totally unaware of her existence as an object.' Again, comparing birth with weaning, he says, 'the traumatic situation of missing the mother differs in one important respect from the traumatic situation of birth. At birth no object existed and so no object could be missed. Anxiety was the only reaction that occurred' (Freud, 1926).

What interests me is precisely the subject of the foetus and the child who is being born, the 'completely narcissistic creature'; I want to know what is actually happening there. I like to think that Freud was feeling round this subject without coming to a final conclusion because of the fact that he lacked certain data which were essential to the understanding of the subject. In considering Freud's view therefore we have constantly to try to remember what he, a scientific worker in the field, would do if he were alive now and active in the psycho-analytic world, taking into consideration advances in our new understanding of infants.

The main thing really is that Freud believed in the significance of birth trauma as a scientific worker, and not only as an intuitive thinker. It is rare to find doctors who believe that the experience of birth is important to the baby, that it could have any significance in the emotional development of the individual, and that memory traces of the experience could persist and give rise to trouble even in the adult. Those who knew Freud, and I am not one of them, may have information as to his latter-day belief in the importance of the birth trauma. In *Group Psychology* Freud says: 'Thus by being born we have made the step from an absolutely self-sufficient narcissism to the perception of a changed outer world and to the beginnings of the discovery of objects'. He goes on to say '... and with this is associated the fact that we cannot endure the new state of things for long and that we periodically revert from it in our sleep to our former condition of absence of stimulation and avoidance of objects'. Here however he is introducing a new subject and I do not take for granted that sleep has a simple relation to intra-uterine existence. This subject needs separate discussion.

[1] This part has had to be re-written (1954) as I discovered Greenacre's work after writing and reading this contribution, although much of her work had been published and was available before the date of my contribution.

I had thought that Freud believed that in the history of every individual there were memory traces of the birth experience which determined the pattern anxiety would take throughout the life of the individual. Greenacre appears to think, however, that Freud linked anxiety with birth by a sort of collective unconscious theory, with birth as an archetypal experience. (I am using Jungian expressions here on purpose because they seem to apply.) But whatever Freud wrote or did not write he held the view that the personal experience of birth is also important to the individual if the following story is true: when he heard of an infant that was born by Caesarian section he remarked that it would be interesting to remember this fact, which might eventually be found to affect the pattern of anxiety in that individual.

Much of what I wish to contribute is already expressed by Greenacre (1945). She writes:

'In summary, it seems that the general effect of birth is, by its enormous sensory stimulation, to organize and convert the fetal narcissism, producing or promoting a propulsive narcissistic drive over and above the type of more relaxed fetal maturation process that has been existent in utero. There is ordinarily a patterning of the aggressive-libidinization of certain body parts according to the areas of special stimulation. Specifically, birth stimulates the cerebrum to a degree of promoting its development so that it may soon begin to take effective control of body affairs; it contributes to the organization of the anxiety pattern, thereby increasing the defense of the infant, and it leaves unique individual traces that are superimposed on the genetically determined anxiety and libidinal patterns of the given infant.'

The matter needs study. Greenacre's two articles (1941) need much more attention that I have been able to give them so far. In the summary of the first of these two papers she says, 'The anxiety response which is genetically determined probably manifests itself first in an irritable responsiveness of the organism at a reflex level; this is apparent in intra-uterine life in a set of separate or loosely constellated reflexes which may become organized at birth into the anxiety reaction', and so on. It may be seen from this that she is asking for a reconstruction of the problem of the relation of anxiety to birth trauma in the light of the work that is being done on infant behaviour.

In the second article, which is more clinical, and more related to psychoanalytic work, Greenacre draws attention to the value to be got from correlating early infant histories with material elicited in the course of subsequent therapy. In her summary she says: 'It is clear that the consideration of these cases takes us back to the need for more observation with infants, work which appears to me the source of the richest material for psycho-analysis.' I expect she would agree, however, that there is no more important method of studying the birth trauma than the one which we have especially at our disposal, namely the psycho-analysis of adults and children. 'The other methods are also important and they include particularly the studies based on observations of infants at birth, before and immediately after birth, and also the type of investigation which can only be carried out by the neurological specialist.'

I would like to draw attention to Dr Grantly Dick Read's work (1942). He sees the birth process from the midwifery point of view, and much of his success

in practice is due to the fact that he adds to his knowledge of the physical side of birth processes a belief in the importance of giving the mother confidence. He aims at preventing or overcoming the fear in the mother which he finds so seriously disturbing to her function at the time of parturition. He is sympathetic to psycho-analysis and psycho-analytic theory. Dr Read is quite willing to believe that the psychology of an individual is something which can be studied prenatally and at the time of birth, and that the experiences at this early date are significant. In this I feel that he is ahead of many obstetricians and paediatricians.

The personal view that I am putting forward in this paper is based on analytic work.[2] My ideas fall into three groups.

The first point I want to make is that there are various types of material appearing in an analysis. When I add to them the birth trauma type of material I am not claiming that treatments can be done on birth material alone. The analyst must be prepared to expect whatever type of material turns up, *including birth material.*

The analyst must indeed expect environmental factors of all kinds. For instance, one needs to recognize and assess the type of environment that belongs to the intra-uterine experience, also the type of environment that belongs to the birth experience; likewise the mother's capacity for devotion in respect of the newborn infant, the capacity of the parental team for taking joint responsibility as the infant develops into a little child; and also the capacity of the social setting for allowing maternal devotion and parental co-operation to play their parts, and for continuing these functions and extending them, eventually enabling the individual to play his or her part in the creation and maintenance of the social setting.

In other words, no consideration of the birth trauma can have value unless a sense of proportion can be maintained. Nevertheless in a discussion of anyone subject one should not be afraid *temporarily* to seem to over-estimate the importance of the subject under discussion.[3]

The second point that I want to make is that in common with other analysts I do find in my analytic and other work that there is evidence that the personal birth experience is significant, and is held as memory material. It is generally held that in psychotic states those very things are remembered that are unavailable to consciousness in more normal states. You will notice that in stating my second point I have used the word 'birth experience' instead of 'birth trauma' and I will return to this point, but first I wish to describe an episode in the analysis of an apparently defective boy whose defect was probably secondary to early psychosis, and not due to brain limitation.

This boy, who was then five, spent a month or two of his analysis testing out my ability to accept his approaches without demanding anything, and actively to adapt to his

[2] It will be observed that I am now leaving the work of other writers and am making an attempt to state my own position in my own words. I am only too happy when after making my own statement, I find that what I have said has been said previously by others. Often it has been said better, but not better for me.

[3] For instance, when I write a paper for this Society on any subject I nearly always find myself dreaming dreams which belong to that subject.

needs in in a way that his mother could not do. He repeatedly came towards me and went away again, testing out my ability to accept him. Eventually he came to sit on my lap. No words were spoken at all for the whole of this period. The further development of his relation to me took the following unexpected form. He would get inside my coat and turn upside down and slide down to the ground between my legs; this he repeated over and over again.

When he had thoroughly established this procedure which seemed to follow his decision that I could be used as the mother that he needed, he would get up from the floor and demand honey. I procured honey (and later cod-liver-oil and malt, which was easier to get during the war) and he would often scoop out as much as half a pound and eat it immediately with great relish. This was the beginning of a tremendous phase of oral activity with excessive salivation. He would make a pool on the doorstep with his saliva as he waited for me to open the door. Previously to this his oral desires only turned up as hallucinated objects (which he called Käfers) which appeared on the walls and of which he was very frightened. The interpretation which had made him able to lose these hallucinated insects was this: that they were his own *mouth*. In the next phase he became a Käfer himself and then he started on the phase of the analysis which I have described, in which he was testing me out as a mother who could actively adapt.

After this experience I was prepared to believe that memory traces of birth can persist. Of course the same thing in play has turned up in many analyses and on still more occasions in the play of normal children and in one's own play as a child.

The following case also presents certain features which help in the approach to the study of birth experience:

Miss H. is a nurse (50 years old). She had treatment from me when she was about 25, at a time when I was house physician at St Bartholomew's Hospital and had only read a book or two on psycho-analysis. This patient had a very severe neurosis, including constipation of a degree that I have never met before or since. She had been shorthand-typist but after getting help from me she became a hospital nurse. Later on she specialized in the care of psychotic children. She has an unusual intuitive understanding of the needs of children who are in a state of regression.

In this patient's treatment, which was cathartic in quality, she would lie and sleep, and then suddenly wake in a nightmare. I would help her to wake by repeating over and over again the words that she had shouted out in the acute anxiety attack. By this means when she wakened I was able to keep her in touch with the anxiety situation and to get her to remember all sorts of traumatic incidents from her very eventful early childhood.

I never knew what to make of her reconstruction of her birth. Birth memories appeared with fantastic embellishments clearly derived from all stages of development and from the sophistication of the adolescent, if not of the adult. Nevertheless the effect seemed to me to be real in its terrific intensity. *While disbelieving the details described as memories I found myself prepared to believe in the accompanying affect.*

Recently this patient has been looking after a little girl of seven, a psychotic case (autistic) undergoing analysis. Miss H. suddenly was taken ill and without being able to let anybody know she simply did not turn up at her job, which was to take the child for treatment and to look after her during the day. I was able to visit her and found that she was just beginning to recover from an illness of a kind that was not new to her, but which had previously never been so acute. She had suddenly had to go to bed with what she called a 'blackout'. She had lain absolutely rigid and curled right up tight on her side, unable to do anything at all, and as near unconscious as may be. A doctor was called in who said he could find nothing wrong with her body. While she was in this condition she was unable to do anything about food at all. Gradually she became conscious, and allowed herself to be moved to a friendly place, and in the course of a week or ten days she was able to get about again. This nurse frequently keeps me in touch with the de-

tails of whatever case she is nursing, but previous to this occasion she had never once, since the time twenty years ago when I was treating her, asked me about herself. On this occasion, however, before going back to her job, she came to me and sat down and said, 'What about this blackout? What had it to do with?' I had no idea, and I told her so. Then she went on talking, and I gradually realized that although she was not expecting to be having a therapeutic session, nevertheless she was giving me from her unconscious the material which would enable me to explain her blackout.

I found that she had been living with this little girl of seven and had been identified extremely closely with the child as she always is with psychotic children in her charge. She told me that in order to understand the child's condition, she had been imitating her more and more, putting a hand here, and walking in this way, and that, and doing everything she saw the child do 'in order to get the feeling of the child's state of mind and body'. Now it so happened that this little girl was going through an acute anxiety state and had developed a very great fear of travelling in the Underground. Miss H. had been trying to take her in the Underground to distract her attention and to show her by experience that the Underground was not as bad as expected. A great deal of material of this kind suddenly showed me that I must say to Miss H. that she herself was reliving the birth experience along with the little girl. Here was no hysterical reconstruction. She had been actually having to re-experience the physical thing, which in her case had included a feeling of asphyxiation. Interpretation along these lines produced a most dramatic effect. Miss H. felt better, felt she understood what was going on, and went back confidently to her job. The doctor of the case said to me, 'Somehow or other Miss H. looks much better since her illness'. After this she continued to do good work with this little girl, and with a more objective understanding of the anxiety that is actually important in the little girl's case.

Hysterical patients make us feel that they are acting, but we know better than they can know that true affect is displayed and hidden in the hysterical manifestations.

In many child analyses birth play is important. In such play the material might have been derived from what has been found out by the patient about birth, through stories and direct information and observation. The feeling one gets is, however, that the child's body knows about being born.

I return to the fact that I used the words 'birth experience' instead of 'birth trauma'. This leads to the third point that I wish to make. I feel that Freud's remarks become very much more understandable when he separates birth experience from birth trauma. Greenacre emphasizes this. Possibly birth experience can be so smooth as to have relatively little significance. This is my own view at present. Contrariwise, birth experience that is abnormal over and above a certain limit becomes birth trauma, and is then immensely significant.

When there has been a normal birth experience, birth material is not likely to come into the analysis in a way that draws attention to itself. It will be there, but if the analyst does not easily think in birth terms the patient is not likely to force the issue in these terms. There will be more urgent and apposite settings for the anxiety which both patient and analyst are trying to reach.

When, however, birth experience has been traumatic it has set a pattern. This pattern appears in various details which will need to be interpreted and dealt with each in its own right, at the appropriate time.

I wish to emphasize, however, that interpretation in terms of birth trauma will not suddenly produce total and permanent relief. It is rather this, that since

the birth trauma is real it is a pity to be blind to it, and in certain cases and at certain points the analysis absolutely needs acceptance of birth material in among all the other material.

It would be useful to give three categories of birth experience. The first is a normal, that is to say healthy, birth experience which is a valuable positive experience of limited significance; it provides a pattern of a natural way of life. This sense of a way of life can be strengthened by various kinds of subsequent normal experiences, and so the birth experience becomes one of a series of factors favourable to the development of confidence, sense of sequence, stability, and security, etc.

In the second category comes the common rather traumatic birth experience which gets mixed in with various subsequent traumatic environmental factors, strengthening them and being strengthened by them.

I refer at a later stage to the extreme of traumatic birth experience, which provides a third category or grade.

It will be seen that it is difficult for me to think that what happens in anxiety is determined by birth trauma, because that would mean that the individual who is born naturally has no anxiety or has no way to *show* that he is anxious. This would be absurd.

I would like to bring in at this point a discussion of the word 'anxious'. I cannot think of a baby as being anxious at birth, because there is no repression or repressed unconscious at this early date. If anxiety means something simple like fear or reactive irritability, all is well. It seems to me that the word 'anxious' is applicable when an individual is in the grips of physical experience (be it excitement, anger, fear, or anything else) which he can neither avoid nor understand; that is to say, he is unaware of the greater proportion of the reason for what is happening. By the word unaware I am referring to repressed unconscious. Should he become rather more conscious of what is afoot, he will no longer be anxious, but instead he will be excited, afraid, angry, etc.

Freud in *Beyond the Pleasure Principle* states: '*Angst* denotes a certain condition as of expectation of danger and preparation for it, even though it be an unknown one.' But he does not seem here to express what I am trying to say, that the individual has to have reached a certain degree of maturity, with capacity for repression, before the word anxiety can be usefully applied. This is an example of the considerations which make me want to ask that the theory of relationship between anxiety and birth trauma should be held in abeyance while work is being done on the psychology of the infant before, during, and after birth.

My present thesis is therefore a composite one, namely that the normal birth experiences are good, and can promote ego strength and stability.

I now wish to draw attention to the way in which birth trauma comes into the analytic situation, making it especially clear that talking with the patient about the birth trauma is something that is extremely likely to be sidetracking the main issue. I would doubt the value of an interpretation along birth trauma lines in the case of a patient who is not deeply regressed at the time in the analytic situation, and who is not clinically ill in the times between analytic sessions.

One of the difficulties of our psycho-analytic technique is to know at any one moment how old a patient is in the transference relationship. In some analyses the patient is most of the time his own age, and one can reach all that one needs of the childhood states by means of his memories and fantasies expressed in an adult way. In such analyses I think there will be no useful interpretation of birth trauma; or birth material will appear in dreams, which can be interpreted at all levels. An analysis, however, may be allowed to go deeper if necessary, and the patient does not have to be very ill to be at times an infant during an analytic session. At such a time there is a great deal that one has to understand without asking for an immediate description of what is happening in words.

I am referring to something which is more infantile than the behaviour of a child playing with toys. According to the predilections of the analyst and according to the diagnosis of the patient there will be variations in the wisdom or unwisdom of working with the patient on these terms. What I am trying to make clear is that if birth experiences are coming into the analytic situation there will certainly be a great deal of other evidence that the patient is in an extremely infantile state.

Birth Experience

It will be understood, Freud having pointed it out, that birth experience has nothing to do with any sort of an awareness of a separation from the mother's body. We can postulate a certain state of mind of the unborn. I think we can say that things are going well if the personal development of the infant ego has been as undisturbed in its emotional as in its physical aspect. There is certainly before birth the beginning of an emotional development, and it is likely that there is before birth a capacity for false and unhealthy forward movement in emotional development; in health environmental disturbances of a certain degree are valuable stimuli, but beyond a certain degree these disturbances are unhelpful in that they bring about a *reaction*. At this very early stage of development there is not sufficient ego strength for there to be a reaction without loss of identity.

I am indebted to a patient for a way of putting this which came from an extremely deep-rooted appreciation of the position of the infant at an early stage. This patient had a depressed mother whose rigidity was marked and who continued after the child was born to hold the child always tightly for fear of dropping her. It is for this reason that the description is in terms of pressure. Together we worked out the following statement which eventually proved to be vitally important in that analysis. The understanding of this reached right down to the bottom of her difficulties and described accurately enough the extent of the regression which she had to make before starting to come forward again in her emotional development. The patient said: 'At the beginning the individual is like a bubble. If the pressure from outside actively adapts to the pressure within, then the bubble is the significant thing, that is to say the infant's self. If, however, the environmental pressure is greater or less than the pressure within the bubble, then it is not the bubble that is important but the environment. The bubble adapts to the outside pressure.' Along with the understanding of this the patient felt that

for the first time, in the analysis, she was being held by a relaxed mother, that is to say, a mother alive, awake, and ready to make active adaptation through the quality of being devoted to her infant.

Before birth, and especially if there is delay, there can quite easily be repeated experiences for an infant in which, for the time being, the stress is on environment rather than on self, and it is likely that the unborn infant becomes more and more caught up in this sort of intercourse with the environment as the time for birth arrives. Thus, in the natural process *the birth experience is an exaggerated sample of something already known to the infant.* For the time being, during birth, the infant is a reactor and the important thing is the environment; and then after birth there is a return to a state of affairs in which the important thing is the infant, whatever that means. In health the infant is prepared before birth for some environmental impingement, and already has had the experience of a natural return from reacting to a state of not having to react, which is the only state in which the self can begin to be.

This is the simplest possible statement that I can make about the normal birth process. It is a temporary phase of reaction and therefore of loss of identity, a major example, for which the infant has already been prepared, of interference with the personal 'going along', not so powerful or so prolonged as to snap the thread of the infant's continuous personal process.

It will be noted that I do not at present hold that it is essentially traumatic to start breathing. The normal birth is non-traumatic by virtue of its non-significance. At the birth age an infant is not ready for prolonged environmental impingement.

It is precisely by reason of its being significant to the infant that experience of the birth trauma is psychologically traumatic. The individual's personal 'going along' is interrupted by reactions to prolonged impingements. When birth trauma is significant every detail of impingement and reaction is, as it were, etched on the patient's memory in the way to which we become accustomed when patients relive traumatic experiences of later life (the sort of experiences that are sometimes successfully recovered by abreaction or by hypnosis). In collecting together examples of impingement I will not attempt to preserve any order because I have not yet decided how to do this; in the study of an analytic patient, however, one meets an order of detail which cannot fail to impress.

It may be pointed out that the most important thing is the trauma represented by the need to react. Reacting at this stage of human development means a temporary loss of identity. This gives an extreme sense of insecurity, and lays the basis for an expectation of further examples of loss of continuity of self, and even a congenital (but not inherited) hopelessness in respect of the attainment of a personal life.

The repeated phases of unconsciousness (here the word is used in the physical sense) either due to brain changes or to the anaesthetic administered to the mother, are unlikely to prove significant. When the patient gives a clear picture of having become unconscious once or several times in this situation it is likely that what is being re-enacted is the snapping of the thread of continuity of the self due to the repeated phases of prolonged reaction to environmental

impingements, such as pressure. Unconsciousness (as after concussion) is not remembered.

Among features typical of the true birth memory is the feeling of being in the grips of something external, so that one is helpless. You will note that I am not saying that the baby feels that the mother is gripping. This would not be talking in terms of a baby at this stage. The point is that the external impingements require the baby to adapt to them, whereas at the birth age the baby requires an active adaptation from the environment. The infant can stand having to react to impingement over a limited period of time. There is a very clear relation here between what the baby experiences and what the mother experiences in being confined, as it is called. There comes a state in the labour in which, in health, a mother has to be able to resign herself to a process almost exactly comparable to the infant's experience at the same time.[4]

Belonging to this feeling of helplessness is the intolerable nature of experiencing something without any knowledge whatever of when it will end. A prisoner-of-war may say that the worst part of the experience is that there is no knowing when the imprisonment will end; this makes three years worse at the time than a twenty years' sentence. It is for this reason fundamentally that form in music is so important. Through form, the end is in sight from the beginning. One could say that many babies could be helped if one could only convey to them during prolonged birth that the birth process would last only a certain limited length of time. However, the baby is unable to understand our language; moreover there is no precedent for the baby to use, no yardstick for measurement. The birth-age baby has a rudimentary knowlege of impingements which produce reaction, so that the ordinary birth process can be accepted by the infant as a further example of what has already happened; but a difficult birth goes far beyond any prenatal experience of impingement that produces reaction.

In the case of one patient in whose analysis there was a particularly good opportunity to watch the birth process, since it was relived repeatedly, I became able to detect each ego nucleus as it appeared in reaction appropriate to the type of impingement. To mention a few: urinary-tract nucleus, flatus nucleus, anal nucleus, faecal nucleus, skin nucleus, saliva nucleus, forehead nucleus, breathing nucleus, etc. Perhaps these considerations throw light on the difficulty we have in describing the weak ego of the immature individual knowing as we do how tremendously strong each ego nucleus is. What is weak is the integration of a total ego organization.

In the present context there is a great deal that can be said about what happens when, with extremely immature ego organization, an infant has to cope with an environment which insists on being important. There can be a false integration which involves some kind of abstract thinking which is unnatural. Here again there are two alternatives; in the one case there is a precocious intellectual development; in the other case there is a failure of intellectual development. Anything in between these two extremes is of no use. this intellectual development is a nuisance because it is derived from too early a stage in the history of

[4] I now call this special state of sensitivity in the mother 'Primary maternal preoccupation', 1957. (See Chapter XXIV.)

the individual, so that it is pathologically unrelated to the body with its functions, and to the feelings and instincts and sensations of the total ego.[5]

Here it may be observed that the infant that is disturbed by being forced to react is disturbed out of a state of 'being'. This state of 'being' can obtain only under certain conditions. When reacting, an infant is not 'being'. The environment that impinges cannot yet be felt by the infant to be a projection of personal aggression, since the stage has not yet been reached at which this means anything. In my opinion a severe birth trauma (psychological) can cause a condition which I will call congenital, but not inherited, paranoia. Observation of many infants in my clinic gives me the impression that a severe paranoid basis can be present immediately after birth. I cannot better illustrate my meaning than by giving you a dream which a patient (woman, age 28, diagnosis: schizophrenia with paranoid features) dreamed in reaction to reading Rank's *Trauma of Birth.*

She dreamed that she was under a pile of gravel. Her whole body at the surface was extremely sensitive to a degree which it is hardly possible to imagine. Her skin was burned, which seemed to her to be her way of saying that it was extremely sensitive and vulnerable. She was burned all over. She knew that if anyone came and did anything at all to her, the pain would be just impossible to bear, both physical and mental pain. She knew of the danger that people would come and take the gravel off and do things to her in order to cure her, and the situation was intolerable. She emphasized that with this were intolerable feelings comparable to those which belonged to her suicide attempt. 'You just can't bear anything any longer. It's the awfulness of having a body at all, and the mind that's just had too much. It was the entirety of it, the completeness of the job that made it so impossible. If only people would leave me alone. If only people wouldn't keep getting at me.' However, what happened in the dream was that someone came and poured oil over the gravel with her inside it. The oil came through and came on to her skin, and covered her. Then she was left without any interference whatever for three weeks, at the end of which time the gravel could be removed without her suffering pain, and when it was taken away her skin had almost entirely healed. There was, however, a little sore patch between her breasts, a triangular area which the oil had not reached, from which there came something like a little penis or a cord. This had to be attended to, and of course it was slightly painful but quite bearable. This simply didn't matter, someone just pulled it off.

Here is much less of the sophisticated overlay than there was in the dreams of the patient Miss H., since the patient was not an hysteric, but was psychotic. Hence the true affect is evident. The person who understood, and who poured oil over the patient was I, the analyst, and the dream indicated a degree of confidence gained through my handling of her case. However, the dream itself is a reaction to an impingement (the reading of Rank's book) and the analysis suffered a temporary set-back.

The Head. In the ordinary birth the head of the infant is the forward point and does the work of dilating the maternal soft parts. There are several ways in which

[5] Idea developed further in 'Mind and its Relation to Psyche-Soma', Chapter XIX.

this is remembered. There may be retained as important a mode of progression which can be described by the word 'reptation'. This word appears in a book by Casteret called *My Caves*. The author is describing the way he gets through holes in deep cave exploration. The point about reptation is that the arms are not of any use, nor the hands. In fact the reason why there is any forward movement is not clearly known to the author. I suppose that in the memory trace of a normal birth there would be no sense of helplessness. The infant would feel that the swimming movements of which we know a foetus is capable, and the movements that I have referred to under the word reptation, produce the forward movement. The actual birth can easily be felt by the infant, in the normal case, to be a successful outcome of personal effort owing to the more or less accurate timing. I do not believe that the facts justify the theory that in the birth process itself there is *essentially* a condition in which the infant feels helpless. Very frequently, however, delay produces this very thing, helplessness, or sense of infinite delay.

There can very easily be delay at a time when there is constriction round the head, and it is my definite view that the type of headache which is clearly described as a band round the head is sometimes a direct derivative of birth sensations remembered in somatic form. In analytic work this band round the head can be found to be related to the experience of being caught up in an environmental impingement that has no predictable end. It is possible to conceive that there are all sorts of sensations not quite so clearly delineated, such as noises, blood rushing to the head, a feeling of congestion at the top, and the feeling 'that something gives way, as if blood is escaping'. These and other common head-symptoms in the psychosomatic field are related to the psychotic delusions in which there is a discharge through the top of the head, and I have known helmets and hoods to be important as providing reassurance that the self will not escape through the top of the head. Scalping has primary significance, and is not merely a castration displacement. Associated with this are all the variations on the theme of horns and unicorns which may derive an important root from the extension forward of the personality in this birth process whereby the body propels itself.

There is a basis here for a fantasy of re-entry into the mother head-first. This was brought out clearly in one analytic experience. The patient, the second of twins, had been unexpected and had been left for a long time after birth unattende. In the analysis there was a time when the patient's dilemma was whether to retain the relationship that was known or to become a separate entity with no external object presenting itself. The former alternative provided a false object relationship and was represented in the analysis at that time by a compulsion to have the hand over the forehead, the hand representing the mother's body. This easily got woven into a kind of false homosexuality in which the patient went into the woman head first. In this case the arms were notably useless. In the first dream she brought to me she was attempting to have intercourse without use of arms and she had developed rheumatoid arthritis confined at first to the elbows and wrists so that arms for which she had no fundamental use had virtually become eliminated. Needless to say, oral erotism was severely inhibited as part of the same complex, and she had already had all her teeth removed.

The identification of the whole body with the male genital often appears in psycho-analytic work. It should not be forgotten that there can be a basis for this in the birth experience in which the body acts as a whole, and without the arms and without oral or any other erotism (except that of the muscles employed in swimming or reptation movements). The body simply proceeds through a narrowed environment.

The Chest. The next in importance to the experiences of the head are those of the chest. This part of my description can be divided into three parts: first there is the memory of actual constricting bands at various levels around the chest. These constrictions can be desired, and we meet this especially in certain perversions, but also in the ordinary details of clothing. One could say that the individual with the strong memory trace of such a thing as a constriction round the chest would rather feel a constriction which is known and under control than continue to suffer from a delusion of a constriction based on memory traces of birth.

The second part of this description is in terms of function. I have found that the memory trace of restriction of chest expansion during traumatic birth process can be very strong, and an important thing about this is the contrast between reactive chest activity and the chest activity of true anger. During the birth process, in reaction to the construction of the maternal tissues, the infant has to make what would be (if there were any air available) an *inspiratory* movement. After birth, if all goes well, the cry establishes the expression of liveliness by *expiration*. This is an example in terms of physical function of the difference between reacting and simply going on 'being'. When there is delay and exceptional difficulty the changeover to normal crying is not definite enough and the individual is always left with some confusion about anger and its expression. Reactive anger detracts from ego establishment. Yet in the form of the cry anger can be ego-syntonic from very early, an expulsive function with clear aim, to live one's own way and not reactively.

The third thing about the chest and birth is the simple feeling of a lack of something, a lack which could be relieved if breathing could be freed. In a case with history of placenta praevia with very much delayed birth and marked asphyxiation, the patient when only six years old complained of a constant feeling of 'lack of oxygen'. She had known before then that the air seemed to lack something, and when she heard of oxygen she used the idea of it immediately. This feeling persisted as a very important symptom. The actual experience of breathing difficulty in the birth process must not be forgotten, in my opinion, when one is tracing out the various roots of breathing disturbances and the perversions that include breathing obstruction. The desire to be suffocated can be extremely strong and turns up as a masturbation fantasy, in the acting out of which many who had no suicidal intention have died. It is present in inverted suicide which is commonly called murder. By a reversal of roles, active suffocating can be a perverted kindness, the active person feeling that the passive one must be longing to be suffocated. There is something of all this, as of everything else, in the healthy passionate sexual relationship.

Study of the need to be able to do without breathing, a need that can be found in the mystical practices of various religions of the East, cannot be complete un-

less the individual's body-memory of his birth can be taken into consideration. There are of course other equally important things entering into the mystic's denial of the necessity to breathe, particularly his attempt to deny the difference between internal reality and external reality.

Conclusions

In order to preserve the personal way of life at the very beginning the individual needs a minimum of environmental impingements producing reaction. All individuals are really trying to find a new birth in which the line of their own life will not be distrubed by a quantity of reacting greater than that which can be experienced without a loss of the sense of continuity of personal existence. The mental health of the individual is laid down by the mother who, because she is devoted to her infant, is able to make active adaptation. This presupposes a basic state of relaxation in the mother, and also an understanding of the individual infant's way of life, which again arises out of her capacity for identification with her infant. This relationship between the mother and the infant starts before the infant is born and is continued in some cases through the birth process and after. As I see it, the trauma of birth is the break in the continuity of the infant's going on being, and when this break is significant the details of the way in which the impingements are sensed, and also of the infant's reaction to them, become in turn significant factors adverse to ego development. In the majority of cases the birth trauma is therefore mildly important and determines a good deal of the general urge towards rebirth. In some cases this adverse factor is so great that the individual has no chance (apart from rebirth in the course of analysis) of making a natural progress in emotional development, even if subsequent external factors are extremely good.

In consideration of the theoretical point of the origin of anxiety it would be a false step to link such a universal phenomenon as anxiety with a special case of birth, birth that is traumatic. It would be logical, however, to attempt to relate anxiety with the *normal* birth experience, but the suggestion is made in this paper that not enough is known yet about the normal birth experiences from the infant's point of view for us to be able to say that there is an intimate relationship between anxiety and normal untraumatic birth. Traumatic birth experience seems to me to determine not so much the pattern of subsequent anxiety as to determine the pattern of subsequent persecution.

Recapitulation

The study of birth trauma is an important study in its own right.

The clues to the understanding of infant psychology, including birth trauma, must come through psycho-analytic experience where regression is a feature. This takes priority over intuitive understanding and even over the objective study of infants and the infant-mother relationship in its early stages.

When birth material turns up in an analysis in a significant way the patient is certainly showing other signs of being in an extremely infantile state. A child may be playing games that contain birth symbolism, and in the same way an adult fre-

quently reports fantasy related consciously or unconsciously to birth. This is *not* the same as the acting out of memory traces derived from birth experience, that which provides the material for study of birth trauma. It is psychotic patients who tend to relive such early infantile phenomena, by-passing fantasy which employs symbols.

I have postulated a *normal birth experience* which is non-traumatic. I have not been able to prove this. Nevertheless in order to clarify my ideas I have assumed the existence of a normal birth experience and have invented two grades of traumatic birth, the one being common, and largely annulled as to its effects by subsequent good management, and the other being definitely traumatic, difficult to counteract even by most careful nursing, and leaving its permanent mark on the individual.

If these assumptions should be found to be justified, there would seem to follow certain theoretical considerations.

Since anxiety is a universal phenomenon it cannot be directly correlated with a special case of birth, namely a traumatic birth.

Perhaps the clue to the well-known fact that there is a relation clinically between anxiety manifestations and the details of birth trauma may be that birth trauma determines the pattern of subsequent persecutions; in this way birth trauma determines *by indirect method* the way in which anxiety manifests itself in certain cases.

A by-product of this theory is that it provides a way of looking at the fairly common congenital, though not inherited, paranoia. The point that I am making is contained in the title of Greenacre's two articles as well as in her text. She writes of a predisposition of anxiety. She does not, however, exactly state that the traumatic birth experience determines the *pattern of expected persecution*. The suggestion is that a traumatic birth experience can determine the existence as well as the pattern of a paranoid disposition. In other words, if one accepts Melanie Klein's theory of paranoid anxiety, in which relief in analysis only comes from a full acceptance on the part of the patient of oral sadism and ambivalence towards the good object, one has to consider what one thinks about the fairly common cases in which the paranoid history dates from birth. My suggestion, which is based on psycho-analytic work, is that in certain cases in which the history goes back to birth, there is so strong a predisposition to ideas of persecution (as well as a set pattern for persecution) that probably the paranoia in such a case is not consequent on oral sadism. In other words, in my opinion there are certain cases of latent paranoia in which the analysis of the paranoia along the lines of recovering the full extent of the oral sadism does not bring about the complete resolution because there is needed in addition a reliving of the traumatic birth experience in the analytic setting. An environmental factor needs to be displaced.

May I be clearly understood? No paranoid case can be analysed by enabling the patient simply to relive the birth trauma. I am only suggesting that in a percentage of paranoid cases there is this additional fact that birth was traumatic, and placed a pattern on the infant of expected interference with basic 'being'. Probably with more experience one could sort these cases out from other paranoid cases according to their clinical picture as well as by very careful history-taking.

In another way I find a link between birth trauma and the psychosomatic disorders, notably certain headaches, and breathing disturbances of various kinds. In this case one could say that the birth trauma can influence the pattern of the hypochondria.

A positive statement can now be made. Freud recognizes a continuity between intra-uterine and extra-uterine life. I think we do not know how much Freud was able to support this intuitive flash from his analytic work. In the very close and detailed observation of one case I have been able to satisfy myself that the *patient was able to bring to the analytic hour, under certain very specialized conditions, a regression of part of the self to an intra-uterine state.* In such a case the to and fro from extra-uterine to intra-uterine existence and back involves experiences that belong to that individual's birth, and this has to be distinguished from the usually more important and more common movement in fantasy in and out of the mother's body and in and out of the patient's inner world.

One can certainly assume that from conception onwards the body and psyche develop together, at first fused and gradually becoming distinguishable the one from the other. Certainly before birth it can be said of the psyche (apart from the soma) that there is a personal going-along, a continuity of experiencing. This continuity, which could be called the beginnings of the self, is periodically interrupted by phases of reaction to impingement. The self begins to include memories of limited phases in which reaction to impingement disturbs the continuity. By the time of birth the infant is prepared for such phases, and my suggestion is that *in the non-traumatic birth the reaction to impingement which birth entails does not exceed that for which the foetus is already prepared.*

It is generally assumed that the new experience of breathing must be traumatic. It is more likely that delay in breathing associated with prolonged birth provides the traumatic factor rather than the initiation of breathing. My psychoanalytic experience makes me think that it is not necessarily true in all cases that the initiation of breathing is significant.

It seems to me that *it is in relation to the border-line of intolerable reaction phases that the intellect begins to work as something distinct from the psyche.* It is as if the intellect collects together the impingements to which there had to be reaction, and holds them in exact detail and sequence, in this way protecting the psyche until there is a return of the continuing-to-exist state. In a rather more traumatic situation the intellect develops excessively and can even seem to become more important than the psyche, and subsequent to birth the intellect can continue to expect and even to go out to meet persecutions so as to collect them and hold them, still with the aim of preserving the psyche. The value of this defence is shown when the individual ultimately comes to analysis, for in the analytic setting we find that carefully collected primary persecutions can be remembered. Then, at long last, the patient can afford to forget them.

I am indebted to Dr Margaret Little for the observation that this may account for the way in which in paranoia scattered persecutions become integrated and organized as in the common clinical picture. The organizing is done by the intellect of the individual in defence of the psyche, and for this reason the organization of scattered persecutions itself is stoutly defended.

A corollary of this is that in some cases there is such a muddle of persecution that the intellect fails to bind and hold the sequence, and in that case instead of

enhanced intellect one finds clinically an apparent mental defect, this in spite of the original normal brain tissue development.[6]

It would be possible to develop this subject by a description of the physical sensations belonging to birth trauma which appear in common psycho-somatic symptomatology. The important thing, however, is that *for the individual patient the pattern is carefully set*, and also that in the reliving which can occur in the course of psycho-analytic work, a definite sequence in time is maintained. In any analysis of this kind of case one becomes familiar with the sensations and their sequence in so far as they belong to that particular patient.

An important practical point in this connection is the way in which *one thing at a time can be dealt with, whereas two or more factors spell confusion.* One of the main principles of the psycho-analytic technique is that a setting is provided in which the patient can deal with one thing at a time. There is nothing more important in our analytic work than that we try to see what the *one* thing is that the patient is bringing for interpretation or for reliving in any one particular hour. A good analyst confines his interpretations and his actions to the detail exactly presented by the patient. It is bad practice to interpret whatever one feels one understands, acting according to one's own needs, thus spoiling the patient's attempt to cope by dealing with one thing at a time. It seems that this is the more true the further back one gets. The integration of the immature psyche at the time of birth can be strengthened by one experience, even a reaction to impingement, provided it does not last too long. Two impingements, however, require two reactions, and these tear the psyche in half. The ego effort which I have described is an attempt to hold the impingements at bay by mental activity, so that the reactions to them can be allowed one at a time and without disruption of the psyche. All this can be very clearly demonstrated in psycho-analytic work provided one is able to follow the patient right back in emotional development as far as he needs to go, by regression to dependence, in order to get behind the period at which impingements became multiple and unmanageable.

Finally, I repeat that *there is no such thing as treatment by the analysis of birth trauma alone.* To arrive at these early stages one has to have shown to the patient one's own competence in the whole range of the ordinary psycho-analytic understanding. Moreover, when the patient has been fully dependent and has started to come forward again, one will require a very sure understanding of the depressive position, and of the gradual development towards genital primacy, and of the dynamics of interpersonal relationships as well as of the urge to attain independence out of dependence.

---

[6] See Chapter XIX.