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EARLY SEXUAL ABUSE AND NIGHTMARES IN THE ANALYSIS OF ADULTS

BY K. ARVANITAKIS, R.-M. JODOIN, E. P. LESTER, A. LUSSIER, AND B. M. ROBERTSON

An examination of the nightmares of four adults in analysis who had been sexually abused as children revealed a characteristic distortion of the body representation as it appeared in the manifest content of the dream. The authors believe that childhood sexual trauma has profound and pervasive effects on the development and consolidation of the body image. Experienced as a grave assault on body integrity and function, it mobilizes primitive anxieties and specific genital anxieties, resulting in distortion, fragmentation, or disintegration of the body representation. The frequently observed multiple somatization of victims of sexual abuse is attributable to such a damaged and persecutory body representation.

INTRODUCTION

Psychoanalytic interest is focusing once again on early sexual trauma as a topic of theoretical exploration and not simply for its relevance to individual clinical cases. Questions about the importance of external reality versus fantasy are being addressed and re-assessed. Shengold (1979) stated that "actual overwhelming *experiences* in the course of the child's development have a different—and more profound—destructive pathogenic effect than do the child's inevitable fantasies of being overwhelmed by aggressive and sexual impulses—fantasies that get attached to the mental images of the most loving and caring parents" (p. 533). Most analysts would probably agree with Shengold's statement, a position never seriously questioned in

the literature. However, the work of Shengold and others on serious mental and physical abuse in childhood raises a number of challenging questions—notably, how to identify the precise mechanisms by which pathogenic bodily stimulation, and the accompanying storm of intense affect, may influence psychic organization and psychic function at particular stages in the child's development.

In an ongoing workshop for the clinical study of the nightmare, we observed that an uncommonly large number of such dreams were reported by analysands who had been sexually abused as children. The work we propose to present here will focus on the relationship between early sexual trauma and a specific type of nightmare reported by these adults in analysis, one in which the body or body parts appear in the manifest content in a distorted, mutilated, or disintegrated form. Although we claim no specificity between these nightmares and childhood sexual abuse, we nevertheless postulate that these dreams reflect the impact of sexual trauma on the development of body representation. The terrors in these dreams refer to the direct assault on the body. The dreams themselves recapitulate both the traumatic experience and the failed attempt to overcome the overwhelming diffuse bodily excitation, and to represent and integrate body parts into a coherent whole, contained and protected by its skin.

After a selective review of the literature on sexual trauma and on nightmares we shall give, as illustrative examples, several typical nightmares from four of our analysands who had been sexually abused as children. We will then venture some hypotheses on the mechanism by which sexual abuse affects the body image as it appears in the manifest content of these nightmares. As our focus here is the body image distortion in the manifest dream, our clinical illustrations will be restricted to this end and will not contain the analysand's associations or our interpretations and working through of the latent content of the material. Fully cognizant of the extreme complexity and multiplicity of interacting factors in the pathogenesis of sexual trauma, and of

the special theoretical and technical difficulties encountered in the analyses of such patients, we will nevertheless, for the purpose of the present report, limit ourselves to our specific focus and thus leave out details of the analytic process as such.

EARLY SEXUAL TRAUMA

Freud (1916-1917) considered traumatic "an experience which within a short period of time presents the mind with an increase of stimulus too powerful to be dealt with or worked off in the normal way . . ." (p. 275). Later, Freud (1920, 1926) related the traumatic process to the breaking through of the stimulus barrier, a break which brings about an acute sense of helplessness. Despite subsequent elaborations, Freud held on to the belief that the process involves the conjunction of an overwhelming external stimulus and a fantasy, together with the instinctual excitation that is triggered. However, he remained unclear about whether the pathogenic (traumatic) stimulus per se was external or internal in origin. Cooper (1986), reviewing the literature, defined psychic trauma as "any psychological event which abruptly overwhelms the ego's capacity to provide a minimal sense of safety and integrative intactness, resulting in overwhelming anxiety or helplessness or the threat of it, and producing an enduring change in the psychic organization" (p. 44). Grubrich-Simitis (1984), studying the effects of severe traumatic experiences (of concentration camp survivors and their children), stressed the specific effect on language, on the capacity to use metaphors. Krystal (1978) emphasized the importance of affect in the phenomenology of trauma. Such phenomenology may be summed up as: a state of psychic paralysis from being overwhelmed, of immobilization, withdrawal, possible depersonalization, and evidence of disorganization as well as possible regression in cognitive function and affective expression.

Turning more specifically to sexual trauma in childhood, a review of the analytic literature since Ferenczi's (1933) pioneer-

ing work attests to the complexity of the factors involved and to the far-reaching consequences of this type of trauma. For Ferenczi, one of the most traumatic elements in the sexual abuse is the child's inability to comprehend the situation, and to understand and deal with the desire of the adult. The noncommunication after the event, resulting from the fact that the perpetrator almost always behaves as if nothing has happened, renders the event truly traumatic. The child, yielding and resisting, is split between guilt and innocence.

Several authors (e.g., Bender and Grugett, 1952) have commented on the difficulty in separating the effects of the sexual abuse from those one may attribute to the general family disorganization and to the emotional absence of the mother. The pervasive damaging effects of serious trauma, Shengold's "soul murder" (which refers to the destruction of the ability to think and to feel), were, in cases of incest, attributed by Ferenczi to the radical discrepancy between the child's need for unambivalent love and the ambivalent sexual relationship imposed by the adult.

TRAUMA AND NIGHTMARES

Psychoanalysts have attempted to understand the etiology, structure, and function of nightmares since Freud drew attention to their complexity in *The Interpretation of Dreams.* In general, repetitive traumatic dreams have been understood as different from other dreams. Rather than being the fulfillment of disguised unconscious infantile wishes, they are seen as the ego's attempt to master, retroactively, a traumatic situation that has proven overwhelming for the psyche. A number of analysts (Myers, 1989; Stewart, 1967), including Freud (1920) himself following his clinical experience with war neuroses, have emphasized the mastery aspect of repetitive nightmares. In 1923, Freud stated that "dreams that occur in a traumatic neurosis are the only . . . exceptions . . . to the rule that dreams are directed

towards wish-fulfillment" (p. 118). In contrast, others have questioned whether the traumatic dream is ever a fully faithful reproduction of the original trauma. The frequently encountered disguise, distortion, and symbolic representation of the original trauma in the manifest content indicates that, as in nontraumatic dreams, the dream work has created the structure for the expression of disguised wish fulfillment in the midst of traumatic repetition (Garma, 1946). Recently, Renik (1981), de Saussure (1982), and Adams-Silvan and Silvan (1990) have posited that psychoanalytic exploration of repetitive dreaming, however traumatic the dream content, reveals the presence of disguised unconscious wish fulfillment. In addition, they suggested that, concealed in the compulsion to repeat the traumatic experience in the dreams, there may be a re-experiencing of some pleasurable component of the original trauma. De Saussure (1982) stated that "the occurrence of the trauma is an indication that in the latent content of the dream an urgent desire has been satisfied and has provoked catastrophic consequences" (p. 168).

Recent sleep and dream research, often undertaken by analytically informed researchers, has presented a challenge to the wish-fulfillment hypothesis. Hartmann (1973), Palombo (1984), Greenberg and Pearlman (1975, 1978) and Winson (1985) have stressed the adaptive functions of REM sleep and dreams, including the restoration of mental functions by the consolidation of memory and cognitive abilities and by mood recuperation. In the nightmare the past traumatic experience, carrying the full load of unassimilated or unassimilable anxiety, is recapitulated in the attempt to incorporate new events in the dreamer's life that bear some real or symbolic connection to the trauma. In addition, the dream represents the attempt to master the trauma itself. The experience of sexual abuse, in common with other major traumatic experiences, such as those in combat, in concentrations camps, catastrophic events, bereavement, etc., calls upon the individual to make major cognitive-affective adjustments. Failure to do so successfully may lead to the development of post-traumatic stress disorders, one of the cardinal

symptoms of which are repetitive dreams reproducing the original experience.

THE NIGHTMARES

Aline, age twenty-two, came for consultation complaining of depression and severe anxiety. In the last year of her undergraduate studies, she feared she would not be able to complete the academic year. She was drinking heavily and was spending a lot of time in bed. She described an obsessive preoccupation that she would be hit by a car. Most of these symptoms had existed for a long time but were exacerbated by her recent, stormy relationship with a much older, divorced man.

The sexual abuse by her father, whom Aline described as warmer than her mother, began when Aline was five, and continued through latency. The parents were divorced when she was eight years old. Following the divorce the father was hospitalized for what was diagnosed as a manic-depressive illness. During adolescence Aline had been mutilating herself, at times severely enough to require hospitalization. Since early childhood she had suffered from severe eczema.

Dream I: I am driving down a highway with my father, and we see that another accident has happened. My father seems unconcerned. I insist that he drive back to the scene of the accident. Somehow, we pass the accident again, I realize that my mother has been in the accident and is there, lying on the side of the road, still breathing. Again, we drive by and I see my mother's body in pieces; her whole body has disintegrated. A body with no arms and no legs.

Dream II: A man is coming toward me from far away; as he approaches, I become increasingly paralyzed by fear: he is dressed in shabby clothes and is so emaciated and weak, he is almost unable to walk. He looks like a skeleton; his flesh is decaying, falling off in pieces of black, bluish flesh. I realize it is my father and wake up in terror.

Leona, forty-eight, came to analysis depressed, discouraged, and feeling at an impasse. Her anxieties were often somatized or expressed in outbursts of anger. Throughout her life she had suffered from severe headaches, stomach aches, and, in recent years, from backaches severe enough to immobilize her for a few days. She was convinced she was doomed to die from breast cancer. She had nightmares all her life.

The only girl with three older siblings, Leona was continuously teased, molested, and terrorized by her brothers, up to the age of nine or ten when she was strong enough to fight back. Her mother, a depressed woman in frail health, never paid enough attention to the girl's complaints and blamed her for being a cry-baby.

> *Dream I*: They were forcing me to swallow bugs in a gluey fluid. I had to keep that stuff inside my stomach and then I would vomit it. I knew the insects could eat up my insides and I thought I must tense up my muscles to stop them. I woke up with an immense pain in my stomach. I was totally exhausted. I thought I would vomit on the bed.

> *Dream II*: My mouth is full of pins, they are stuck in my gums, in my teeth. I lean forward to spit them out. The more I spit, the more they are there. The pins become safety pins and then paper clips connected with one another. I keep pulling them out and suddenly I realize it is my guts I am pulling out. If I keep doing it, I will die. I wake up in terror.

René, a thirty-two-year-old university professor, entered analysis because of debilitating performance anxiety and the inability to carry out his work requirements. He has been a practicing homosexual since his early teens. He grew up in a chaotic family where violent scenes between the parents were not unusual. His father was an alcoholic, and the parents eventually divorced when René was eight years old.

René was obsessed by fears of AIDS and death. He feared that he might be assassinated or become the victim of a serial killer. Following his first nightmare in the analysis (being chased by his

father through long corridors and a confusing scene in a shopping mall), René remembered having been sexually abused at the age of four or five. His father had brought a man he met in a bar to the house; both were in a drunken state. "I was seated on his lap and he was touching my genitals; my father sat just opposite to us watching. It happened on several occasions."

Dream I: My body is decaying. I can see my head. It is turning black, the color of decay. [He associated to a relative whose toe became gangrenous and had to be amputated.] Can you die from a decayed toe?

Dream II: I only remember fragments: the inside of my penis was coming out of my urethra; there was red flesh dangling, popping out. I was horrified. I was trying to rip off the red flesh, to tear it away. Like a tear, or something, a rupture, not like disintegration.

Dream III: In the dream there is a sense of loss; I despair, all I have is my mind . . . somebody without a body . . . no boundaries. I have to be carried around in a plastic bag.

Wendy, twenty-six, divorced, came for consultation for a chronic depression and suicidal thoughts, exacerbated following the death of her father. At the age of eight, Wendy had been sexually abused by a long-term friend of the family, a married man in his late twenties. The abuse continued until she was thirteen. The sexual activities were largely confined to mutual fondling, masturbation, fellatio, and cunnilingus; an attempt at intercourse when Wendy was twelve had to be given up because it proved to be too painful for her. Wendy had several difficulties in her sexual life: after an initial strong attraction to a man she would feel disgusted and repelled by his sexual demands. Her masturbatory fantasies usually involved a man *and* a woman, a beautiful, much admired woman.

Dream: It was me, it was my body . . . it was from my body . . . it wasn't clear blood, or it wasn't what it was and I couldn't stop it, it just kept coming and coming . . . it was like dirt, but not

dirt off the street, like all brown . . . it couldn't stop coming, and as much as I wiped and cleaned . . . like the same place as if I was having a period, except it wasn't blood . . . it was like brown and white sort of mixture, it was like dirt and sperm. I kept trying to clean up with a cloth but it just couldn't stop.

DISCUSSION

The manifest content in the nightmares reported above strongly suggests that the anxieties these dreams attempt to bind and master are largely located in the bodily self. The fragmented, distorted, mutilated, or totally disintegrated body in the dreams reflects, in our opinion, the profound impact of the sexual trauma on the development and consolidation of the body representation in these patients.

Schilder's (1935) concept of body image or body schema refers to an integrated mental structure of the totality of one's sensory, motor, and affective (pleasurable or unpleasurable) bodily experiences. Schilder stressed the continuous evolution, fluidity, and mobile boundaries of the body schema as it integrates the flow of sensations, affects, and, eventually, fantasies and thoughts pertaining to the body. Thus, the totality of all these sensations, etc., in the somatic sphere, are organized in somatic schemata.

The terms body image, body schema, and body representation are often used interchangeably in the literature. Following Schilder's work, the term body image was taken to mean a structure of the ego comprising all bodily experience throughout life. However, with the shift in focus from ego functions to the representational world and to the structuring of the self and the object through the internalization of self and object representations in an interpersonal, interactional field, the term body representation(s) came into common use. It is this term, body representation(s), that we will use in this paper.

The development of the body representation is a dynamic process evolving throughout the psychosexual stages. It is con-

tinuously subjected to reorganizations and elaborations brought about by the ascendancy of the different erotogenic zones, and by the object relations associated with these. As Torras de Beà (1987) stated: "This representation [of the body] is organized throughout the process of development; its integration ebbs and flows according to the variability and vulnerability of the internal objects, and is influenced and remodeled by all the subject's experiences—*specifically, those directly connected with the body*" (p. 176, italics added).

The body representation includes:

(1) A sense of the body self existing autonomously, contained and protected by its dermal shield—the skin—and maintaining permeable psychic boundaries with the affective objects and *their* bodies. In pathologic states such permeability may result in the fantasy of fusion of self and object body representations. The importance of the skin was underlined by Anzieu (1985), "The infant comes to perceive its skin as a surface as it experiences the contact of its body with that of the mother, and within the framework of secure attachment to her. Thus, it arrives not only at the notion of a boundary between the exterior and the interior but also at the confidence required for progressively mastering the orifices, for it cannot feel confident as to their functioning unless it also possesses a basic feeling which guaranties the integrity of its bodily envelope" (p. 39). This psychic "container" (Bion, 1970), a permeable and, in extreme cases, a "perforable" envelope, relates to the primary anxiety of the vulnerable child, of "a flowing away of vital substances through holes, an anxiety not of fragmentation but of emptying" (p. 39).

(2) The integration of body parts into a well functioning and coherent sense of bodily self. Pathology here refers to hyper- or hypocathexis of body parts (often the result of excessive stimulation or the defensive disavowal of such parts); furthermore, pathology may be manifested in the unstable integration of the parts into the whole, which results in a sense of vulnerability of the body self and in excessive anxiety. Anxiety in turn leads to fragmentation or bodily breakdown. It is our belief that the

excessive somatization seen clinically in patients who were sexually abused in childhood is related to this sense of vulnerability of the bodily self, as well as to the anxiety associated with the awareness of poorly integrated bodily functions and sensations. Anxiety is equally related to the awareness of the impairment of the body's ability to absorb and discharge tensions and excitations.

Several authors (Anzieu, 1985; Greenspan, 1989; Mahler and McDevitt, 1982; Stern, 1985; Torras de Beà, 1987) have discussed the interactional matrix within which most bodily experiences take place in early life, stressing the particular role of the mother for the healthy evolution of the body self. The libidinal cathexis of the baby's body by the mother is, according to Mahler and McDevitt (1982) the "*sine qua non* of the earliest sense of the body self as an entity" (p. 833). Maternal "holding" and "handling" (Winnicott, 1945, 1971) play a cardinal role in the early unification of unintegrated experiences of body parts into a coherent body representation, permitting a stable sense of a body, inhabited by the subject, and constituting an integral part of the self.

Bernstein (1990) made an important contribution to the understanding of genital anxieties which are specific to women and which play a role in the formation of female body representation. She pointed out that although "castration-like" anxieties are not uncommon in women, they do not "serve exclusively or even dominantly to describe women's genital anxieties" (p. 153). Instead, anxieties related to genital access, penetration, and diffusivity of excitation are much more common. Bernstein believes that what adds to the difficulty of forming firm body boundaries is the girl's "experience with the unfocused, open, penetrable nature of her genitals . . ." (p. 163).

Regarding the nightmares of the sexually abused analysands: in the content of these dreams the frequency of a sadistic attack on the body, either from the outside or from the inside, accompanied by a frightening lack of control and the danger of annihilation, suggests that the sexual assault intensifies genital anx-

ieties, centering on issues of access, penetrability, and diffusivity in the girl, and, in the boy, on castration anxiety. Furthermore, it would seem to mobilize other primitive anxieties and render all anxiety resolution problematic. In turn, such intense and disorganizing anxieties would cause disruption of body representation and of the sense of intactness and wholeness of the body as contained in its epidermal coverage.

A sexually abused child, receiving directly on her body the impact of the aggressor's erotic and aggressive impulses, must be profoundly shaken by the aggressor's behavior and some of the changes she may perceive in his body (erect penis, flushed intense look, ejaculation), in addition to what she experiences within her own body. The lack of control and the inability of the child to comprehend clearly what is happening, often intensified by the aggressor's denial of his contribution to the events, would make it particularly difficult for the child not only to maintain some sense of reality but also to establish a clear differentiation between her body and that of her abuser. In the child's fantasy the body could become the locus of mysterious and frightening changes, in themselves generating further anxieties. In the dreams these primitive anxieties emerge in the form of the body decaying and disintegrating, of being amputated with shreds of the skin falling off, or in the form of an endless loss of bodily fluids. The whole experience is beyond the child's capacity to understand, control, discharge, and assimilate. Frequently, it is the rage engendered by these experiences of sexual abuse, rage "at a cannibalistic pitch (threatening destruction of both self- and parent imagoes . . ." (Shengold, 1979, p. 555) that is most terrifying and overwhelming for the victim.

If the sexual assault occurs before some integration of the body representation has been achieved, the sexual assault has a profound disorganizing and fragmenting effect on the body self. The overwhelming stimulation cannot be contained in any specific locus but instead invades the whole of the body. This may lead to a defensive dissociation of, and distancing from, the sensory body, leaving the body image unstable and vulnerable to

subsequent real or fantasized attacks on the body. The dream re-creates the experience of dissolution and fragmentation of the body. Primitive sadistic fantasies of the primal scene can also be revived or developed through the impact of the trauma: "my mother has been in [an] accident. . . . I see my mother's body in pieces, her whole body has disintegrated." "[My father's] flesh is decaying, falling off in pieces of black, bluish flesh" (Aline's dreams).

Another aspect of such dreams is the externalization of the assault which, in addition to its defensive function, may serve some adaptive measure; i.e., it may represent an attempt to develop cognitive control over the effects of the attack on the body: "I was looking, someone else was attacked," means not only it was not happening to me but also, "I can see what and how it was happening." Vision provides a powerful substratum for adequate ego functioning from very early in life, and seeing helps understanding and mastering. The sexual assault may mobilize anxieties related to a very primitive body representation, one in which, according to Rosenfeld (1984), there is a loss of "the psychological notion of skin" and the body scheme is felt as "a vital fluid . . . contained by a weak membrane or wall" (p. 382). This may be illustrated by Wendy's dream images of endless evacuation of body fluids and by René's dream where he feels he is "somebody without a body . . . no boundaries. I have to be carried around in a plastic bag." If the abuse happens later, the reliving of the trauma takes place within the dreamer's own body and with a varying degree of symbolization.

If the abuse takes place somewhat later, but before the oedipal resolution, as in the case of Leona, the diffusion of the sexual excitement to other parts of the body is bound to bring about a confusion of the genital sensations with those of anal and oral experiences. This, on the one hand, leaves the evolving representation of the genitals particularly susceptible to be drawn and fixated into conceptualizations and fantasies belonging to these zones and stages, and, on the other, it invests the oral and anal

representations with the fantasies and anxieties belonging to the sexual assault.

The inability to assimilate or effectively discharge the excessive sexual stimulation and other bodily tensions endured during the sexual assault, in addition to the confusion it creates as to the source of the experience, may result in the formation of persecutory fantasies and paranoid anxieties relating to the child's body and its functions. This is illustrated in Leona's dream of being forced to swallow deadly bugs who would "eat up my insides" unless she could tense up her muscles and immobilize them; similar paranoid fears may be seen in the dream where her mouth was full of pins "stuck in my gums." Although these oral fantasies may relate to experiences of fellatio or attempted fellatio, they also suggest the presence of paranoid persecutory fears relating to the body's inability to deal effectively with the sexual penetration.

We believe that such damaged and persecutory body representations may account for the analysands' multiple somatizations, occasional self-mutilations, and suicidal attempts. Somatization, a very common symptom with patients who had been sexually abused in childhood, is seen here as closely related to a sense of a damaged body and body parts. Worse still, the body itself may be experienced as a persecutory object to be attacked and gotten rid of. The victim thus engages in a circular path with no outlet, in which the body that has suffered aggression becomes its own aggressor, reliving forever the unbearable, painful bodily stimulation. An effort to re-externalize the trauma and the attempt to take control by reversing passivity into activity may lead, in adolescence and young adulthood, to sexual promiscuity and perversity.

The various means by which the victim of sexual abuse tries to discharge, master, or defend against the excessive bodily stimulation and the accompanying affective storm—e.g., the dissociation and distancing, the autostimulation and self-mutilation, the repetition in fantasy and reality, all these means will, in turn,

affect the body representation and, by implication, even the self-representation.

REFERENCES

ADAMS-SILVAN, A., & SILVAN, M. (1990). 'A dream is the fulfilment of a wish': traumatic dream, repetition compulsion, and the pleasure principle. *Int. J. Psychoanal.*, 71:513-522.

ANZIEU, D. (1985). *The Skin Ego.* New Haven/London: Yale Univ. Press, 1989.

BENDER, L. & GRUGETT, A. E. (1952). A follow-up report on children who had atypical sexual experience. *Amer. J. Orthopsychiat.*, 22:825-837.

BERNSTEIN, D. (1990). Female genital anxieties, conflicts and typical mastery modes. *Int. J. Psychoanal.*, 71:151-165.

BION, W. (1970). *Attention and Interpretation. A Scientific Approach to Insight in Psycho-Analysis and Groups.* London: Tavistock.

COOPER, A. M. (1986). Toward a limited definition of psychic trauma. In *The Reconstruction of Trauma: Its Significance in Clinical Work*, ed. A. Rothstein. New York: Int. Univ. Press, pp. 41-56.

DE SAUSSURE, J. (1982). Dreams and dreaming in relation to trauma in childhood. *Int. J. Psychoanal.*, 63:167-175.

FERENCZI, S. (1933). Confusion of tongues between the adult and the child. (The language of tenderness and of passion.) *Int. J. Psychoanal.*, 1949, 30:225-230.

FREUD, S. (1916-1917). Introductory lectures on psycho-analysis. *S.E.*, 16.

——— (1920). Beyond the pleasure principle. *S.E.*, 18.

——— (1923). Remarks on the theory and practice of dream-interpretation. *S.E.*, 19.

——— (1926). Inhibitions, symptoms and anxiety. *S.E.*, 20.

GARMA, A. (1946). The traumatic situation in the genesis of dreams. *Int. J. Psychoanal.*, 27:134-139.

GREENBERG, R. & PEARLMAN, C. A. (1975). A psychoanalytic-dream continuum: the source and function of dreams. *Int. Rev. Psychoanal.*, 2:441-448.

——— (1978). If Freud only knew: a reconstruction of psychoanalytic dream theory. *Int. Rev. Psychoanal.*, 5:71-78.

GREENSPAN, S. I. (1989). *The Development of the Ego: Implications for Personality Theory, Psychopathology, and the Psychotherapeutic Process.* Madison, CT: Int. Univ. Press.

GRUBRICH-SIMITIS, I. (1984). From concretism to metaphor. Thoughts on some theoretical and technical aspects of the psychoanalytic work with children of Holocaust survivors. *Psychoanal. Study Child*, 39:301-319.

HARTMANN, E. L. (1973). *The Functions of Sleep.* New Haven/London: Yale Univ. Press.

KRYSTAL, H. (1978). Trauma and affects. *Psychoanal. Study Child*, 33:81-116.

MAHLER, M. S. & MCDEVITT, J. B. (1982). Thoughts on the emergence of the self, with particular emphasis on the body self. *J. Amer. Psychoanal. Assn.*, 30:827–848.

MYERS, W. A. (1989). The traumatic element in the typical dream of feeling embarrassed at being naked. *J. Amer. Psychoanal. Assn.*, 37:117-130.

PALOMBO, S. R. (1984). Deconstructing the manifest dream. *J. Amer. Psychoanal. Assn.*, 32:405-420.

RENIK, O. (1981). Typical examination dreams, "superego dreams," and traumatic dreams. *Psychoanal. Q.*, 50:159-189.

ROSENFELD, D. (1984). Hypochondrias, somatic delusion and body scheme in psychoanalytic practice. *Int. J. Psychoanal.*, 65:377-387.

SCHILDER, P. (1935). *The Image and Appearance of the Human Body. Studies in the Constructive Energies of the Psyche.* New York: Int. Univ. Press, 1950.

SHENGOLD, L. (1979). Child abuse and deprivation: soul murder. *J. Amer. Psychoanal. Assn.*, 27:533-559.

STERN, D. N. (1985). *The Interpersonal World of the Infant. A View from Psychoanalysis and Developmental Psychology.* New York: Basic Books.

STEWART, W. A. (1967). Comments on the manifest content of certain types of unusual dreams. *Psychoanal. Q.*, 36:329-341.

TORRAS DE BEA, E. (1987). Body scheme and identity. *Int. J. Psychoanal.*, 68:175-184.

WINNICOTT, D. W. (1945). Primitive emotional development. *Int. J. Psychoanal.*, 26: 137-143.

——— (1971). *Playing and Reality.* London: Tavistock.

WINSON, J. (1985). *Brain and Psyche. The Biology of the Unconscious.* Garden City, NY: Anchor Press/Doubleday.

K. Arvanitakis, M.D.
653 Grosvenor Ave.
Westmount, PQ
Canada H3Y 2S9