

The Prenatal Experience: Psychotherapeutic Situation and Possibilities for Prevention

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Abstract: In recent years, observations from different scientific areas have supported the assumption that in an unrecognised way pre-speech experiences are much more present and influential in an individual than previously supposed. The act of remembering pre-speech memories is an active or passive re-enactment of the past. Based on this concept of emotional and action-based memory, a more concrete interpretation of the pre- and perinatal roots of emotions and actions in the psychotherapeutic situation is possible. Examples are given and consequences for prevention are discussed.

Introduction

In the past 20 years, there has been a dramatic change in the way in which we view the reality of life and experience in the infant and prenatal stage. In this context, the beginning of speech in the second year of life seems to have been an important threshold. The ability to speak formed the basis for mutual understanding, and the development of the ability to express oneself through speech was thus regarded as the “psychological birth” in humans. The world in which the infant and the unborn child lived could not be understood in a direct, speech-related way and therefore seemed to be part of a dim and distant past. Moreover, a child in the pre-speech stage was defined by its apparent deficits, e.g. it could not speak, it was unable to communicate what it sensed and experienced, and it could not walk. Indeed, it was often thought that infants were incapable of sensing and experiencing things and that they had no inner life at all; they were regarded as creatures governed by their reflexes. People reduced infants to “reflex entities” in an attempt to be “scientific” and to only describe factors that could be clearly objectified and measured. At the same time, however, this was also a form of defence that was put up against the reality of our pre-speech experience as a result of our one-sided identification with our speech-orientated selves.

As has already been mentioned, a change has now taken place in the scientific community and in public opinion. In the last few decades and in stark contrast to earlier times, people have begun to systematically examine infants' behaviour and their relationships with their mother or father. In the last few years, this area of research, now known as "infant research", has received a certain amount of attention. The objectification of infant behaviour captured on film played an important part in this. By recognising and analysing on film the wealth of interaction that takes place between mother and infant, it became easier to recognise more clearly such interaction in real-life situations. A concomitant, but less prominent development was the investigation and observation of the unborn child. Here, too, film material and ultrasound images played a significant role. As a result of becoming visible on film and in photographs, the unborn child took on a greater reality in our general consciousness. However, the pictures that document the behaviour of the unborn child are less comprehensive than those showing infant behaviour. It is also much easier to be receptive to the world of infants, quite simply because we live in the same world as they do. The unborn child, on the other hand, is more or less in another world. If we are to understand it in the reality of this other world, it is vital for us to remind ourselves and to truly become aware of the fact that we, too, once lived in a similar world. If we put ourselves in the place of the unborn child, we have to not only do without the familiarity of language, as we do in our dealings with infants, but also to do without sight, a faculty that gives us a feeling of security and a sense of orientation in the world. An additional factor is the lack of gravity, a force which determines our sense of place after birth. The considerable differences between the prenatal and the postnatal sphere are one of the main reasons why the reality of prenatal life has been denied as part of our life-history to the extent that it has been. The research that has been carried out over the past few decades into prenatal experience is a way of overcoming this denial. Two groups acted as forerunners and paved the way for this form of research: artists and psychoanalysts. I will begin by discussing art.

Discovery of the Pre-speech Child in Art

The major turning-point in modern art around the turn of the century essentially consisted in the fact that, in artistic representation, the boundaries of our world as generally defined by our speech-related consciousness were extended to include the representation of pre-speech experiences. An important example of this tendency is provided by Franz Kafka, who used symbolic narrative to make experiences from very early childhood directly accessible, e.g. the sense of being abandoned like an animal and the physical alienation experienced by the neglected child in *Die Verwandlung* ("Metamorphosis") or the lack of fulfillment and emptiness of the child born into a situation without any supportive relationship in *Ein Hungerkünstler* ("A Hunger Artist"). Like the unwanted baby, the hunger artist refuses to eat, because he doesn't like the taste of any food. When the animal supervisor at the circus asks him why his hunger is not something admirable, he gives the following explanation: "Because I have to fast, I cannot help it" . . . "What do you mean", said the supervisor, "why can't you help it?" And the hunger artist lifted his head a little and spoke into the supervisor's ear so that nothing was lost, his lips puckered

as if to kiss him: "Because I haven't been able to find the kind of food I like. If I had found it, believe me, I wouldn't have made any fuss, I would have eaten my fill just as you and everyone else does" (cited from Miller 1981, p. 353). This scene shows very clearly how Kafka illustrates the continuation of the infant's refusal of food by the hunger artist.

The experience of an incomplete birth, of not arriving in a welcoming relationship with the mother or the parents, is a major theme in the work of Samuel Beckett. Beckett's protagonists are not really born, they are thrown into the world. They wander around in the world like clowns, in search of their lost home. Beckett's biographer, Deirdre Bair, summarises Beckett's insight into the nature of his birth as follows: "If he was not perfectly born, if he had true prenatal memories and remembered his birth as painful, it seemed to him only logical that this ill-fated and defective, first happening in life had led to the unsatisfactory and imperfect development of his personality" (Bair 1978, p. 209).

In *Waiting for Godot*, one of Beckett's protagonists says: "... one day we will be born, one day we die, on the same day, at the same moment. Is that not enough for you. They gave birth astride the grave, the day lights up for a moment and then once again it is night" (Beckett 1976, p. 94). Another character in the play repeats this idea at the end in a very similar form, the fact that the birth goes wrong turning the birth attendant into a grave digger: "Astride the grave and a difficult birth. Out of the depths of the pit, the grave digger as in a dream applies the forceps" (Beckett 1976, p. 96).

The prenatal period of life as a major influence on the way he experienced life and as the source of his art was a central theme in the work of Salvador Dali. He was conceived as a substitute for an older brother who had died and described the effects of this on his prenatal life as follows: "My parents' despair (due to the loss of the brother) was only soothed by my birth but every cell of their body had sucked itself full of their grief. My fetus swam in a hellish placenta. I have never been able to get rid of this affliction . . . The intrauterine paradise was the colour of hell, that is, red, orange, yellow, bluish, the colour of flames, of fire. Above all else, it was warm, immobile, soft, symmetrical, duplex and sticky" (Dali 1973, p. 10, 1984, p. 42).

With regards to his method of creating internal prenatal images, he wrote as follows: "I go down on all fours so that my knees and my hands are touching. I allow my head to hang down under its own weight and to swing like a pendulum so that lots of blood runs into it. I do this exercise until a pleasurable dizziness sets in. Without having to shut my eyes, I see phosphorescent rings emerging out of the pitch black darkness . . ." (Dali 1984, p. 47).

This process of transgressing their inner life by re-enacting pre-speech experience even as far back as the prenatal period was very much a conscious process in many modern artists. Paul Klee spoke of worlds being opened up to us, by which he meant the "realm of the unborn", with which children, the insane and primitive tribes "probably still have more direct access" (Klee 1975, p. 58).

Discovery of the Pre-speech Child in Psychoanalysis In a similar way as in art, around the turn of the century the boundaries of our speech-orientated awareness of the self were pushed back to include pre-speech experience. Freud described this widening of focus in psychotherapy in a highly complex way using the example

of disturbances in the early formation of sexual identity in the so-called Oedipus phase. These disturbances in the process of developing a clear male or female identity seemed to arise in the wake of conflicting pre-speech urges in the oral and anal phase or to be caused by phylogenetically determined original anxieties. Freud assumed that repressive tendencies and defence mechanisms in later life had their roots in a very early experience of repression or in a narcissistic trauma, which, however, he was unable to characterise in greater detail. His pupils Rank and Graber subsequently identified the cause of original repressive tendencies and anxiety as being the trauma of birth and the experience of separation and the change of worlds it involved (Rank 1924; Graber 1924). The Hungarian psychoanalyst Fodor (1949) went on to describe in detail the effects of traumatic prenatal experiences.

What these psychoanalysts and artists managed to achieve was a broadening of consciousness in two directions: firstly back into the pre-speech period of life, and secondly towards a holistic view of the present way in which we see and experience ourselves. In an attempt to put this into words, the psychoanalyst C.G. Jung suggested that the way in which we see and experience ourselves should be described using two expressions: the self and the ego. The ego is identical to the "speech ego" that develops in the second year of life and that relates us to the social sphere in which we grow up. The self is to some extent the pre-speech ego that develops in the course of experiences in the pre-, peri- and postnatal period and that accompanies us throughout life in the form of non-verbal experiences and sensations. A division similar to that into the self and the ego is found in modern research into memory, which distinguishes between a verbal memory and an action-based memory (for references, see Share 1996). The action-based memory is already active in the prenatal period and constitutes a vital point of reference for us in our behaviour and experiences. The verbal memory develops in the second year of life, and from this time onwards it serves as a conscious reference point in our linguistically organised world.

The findings of modern research into states of consciousness can be summarised as follows: the pre-speech child is conscious in the same way that the higher mammals are (Edelmann 1989) and lives in a kind of constant present. What is important to the child in an emotional sense is experienced as something in the present. The act of remembering at this level of consciousness is therefore an active or passive re-enactment of the past. In contrast, verbal consciousness is regarded as being secondary. It is self-reflexive, and past, present and future are clearly distinguished from one another.

These ideas allow us to take a fresh look at the observations that have been made in the psychotherapeutic setting. This setting is partly characterised by verbal aspects and partly by non-verbal ones, which may be rooted in the pre-speech period of life or in the non-verbal experiences of later development. An effective way of gaining access to non-verbal elements is to ask patients about the way in which they see themselves and the way in which they experience life. The level of verbal memory can be reached by asking about events and circumstances that can be described in words and which the patient then goes on to talk about. Events that occur in the pre-speech period of life are peculiar in that the speech ego cannot remember them and thus they cannot be described. They can only be communicated

symbolically, visually or by way of re-enactment, and such communication cannot be directly related to one particular event. An unexplainable feeling of strangulation may suggest that the umbilical cord was wrapped around the patient's neck; however, this assumption can only be verified by an eye-witness account, e.g. a report of the birth. It took a long time until the distinction between action-based memory and verbal memory became clear enough for the presence of early experience in the psychotherapeutic setting to be truly accepted. The results of these efforts will be illustrated below using various examples.

Visual Re-enactment of Pre- and Perinatal States with the Use of LSD

In the 1970s, the use of LSD made it possible for many people to go beyond the limits set by their verbal consciousness and to reach their pre-verbal consciousness. The possibilities LSD offered in terms of research were recognised and grasped by the Czech psychoanalyst and psychiatrist Stanislav Grof. He gave patients LSD and managed to assign the images and sensations to which they gained access to various pre-speech levels, in particular the prenatal level and the perinatal phases (Grof 1988).

As an example of the re-enactment of the feelings and sensations of birth through the use of LSD, I would like to cite the American obstetrician Leny Schwartz: "After twenty minutes I began to feel the effect of the drug . . . The spiral form with which I had identified myself transformed itself into a dark, cavelike room. I felt its boundaries . . . I began to move myself slowly down a long tunnel. The walls bulged rhythmically in and out. They were made of a damp material which was making pulsating, contracting, and expanding movements. At the end of the tunnel, there was a blue light . . . Suddenly everything changed. I felt an unbearable pressure on my head and body, a terrible pain. I was being pushed backwards by an overpowering force but it was impossible to move forward. Instead, the soft walls got narrower. All movement stopped. I was trapped, near to suffocation and too small and powerless to fight against the unexpected force . . . There was no exit, I could not go forwards or backwards. Then, just as unexpectedly as the movements had stopped, they began again. The pulsating was intense and rhythmical. I began to fight in earnest and to work my way forwards. I wept and cried often because of the pain . . . Then the battle suddenly stopped and I broke out of my prison into a place of clear blue light. This expulsion was accompanied by an intense pain in my neck. I gasped for air . . . I was exhausted but free" (Schwartz 1983, p. 103).

As in all such examples of experience with LSD and in case reports from the field of psychotherapy, verbal and non-verbal elements are intermingled, as are elements and categories of adult life with elements from early and very early periods of life. In regressive experiences such as these, early, pre-speech experience is re-enacted by the speech ego. Of particular importance in psychotherapeutic terms are the findings of the Greek psychiatrist Kafkalides, who had patients undergoing psychotherapy take LSD and report their experiences. As a result of what he observed, Kafkalides developed the concepts of the "rejecting womb" and the "accepting womb" to characterise the continued presence of the very early prenatal relationship with the mother in the later experience of the patient. The following example serves to illustrate the experience of the "rejecting womb".

The patient was a 20-year-old single woman who had been extremely anxious and insecure ever since she was a child. She was afraid of everything and everyone and could find nothing that gave her any support. All she had were guilty feelings, and she punished herself and suffered on account of these feelings. The following passage is taken from the records of her experience with LSD: "As I saw my mother pregnant, I felt that I was in her belly and that she was hitting me dreadfully. It became clear to me that she wanted to abort me and I felt frightened because everyone was against me and I felt very weak . . . The womb is something unclean. It contains paper rubbish and broken glass. When someone manages to get in there, he ceases to exist. It is like a grave, like being in a plastic bag . . . I cannot see the sea because it is drowning me. And as I am drowning, I become a small baby, a fetus, and then . . . then the grave is there . . . And if I did not exist in the womb, how could I believe that I have ever existed? . . . I feel permanently dead and permanently defend myself . . . When will I get out of this situation? . . . It is black. I come out naked and people do not like others who are naked. I feel as though I am burning . . . I can see black ash . . . What is it? The womb is everywhere. I enter the world as if I have been burned. After my birth, I have come out of the womb but I cannot resist it because everywhere I am I feel as if I am still inside of it. I have the feeling that I have always got the womb around me even though I am outside of it . . . Now I am still the small, dirty child that they did not want" (cited from Janus 1991, p. 120; Kafkalides 1995).

This example clearly shows the extent to which very early pre-speech experiences can dominate the way in which we come to see ourselves and experience life. Due to the presence of our speech ego, we always run the risk of underestimating the reality of life and experience in the pre-speech period.

Pre-speech Experience in the Psychoanalytic Setting The above-mentioned findings of modern research into memory (Cahill et al. 1994), research into the post-traumatic stress disorder (PTSD) (Terr 1990) and the examples cited of experimentation with LSD and in other psychotherapeutic settings, such as primary therapy and various kinds of body and regression therapy (Hollweg 1995), indicate that pre-speech elements are present in the psychotherapeutic setting to a much greater extent than was earlier thought probable. One of my own examples concerned a woman of about 30 who felt constrained during the sessions and complained that her skin felt unpleasant, like leather. This feeling of discomfort increased in the course of the sessions until we managed to identify a connection between her having become stuck during birth and the premature breaking of the amniotic sac. After this was initially discussed, the patient dreamed of a medieval town through which modern thoroughways were suddenly being built. The nature of her physical discomfort changed, as did the content of her dreams. She had always dreamed that she was driving a motorbike and then fell off and could not drive any further. She became more and more proficient at steering the motorbike and eventually took a zigzag road down a mountain. At the same time, the way in which she experienced life and the world also changed. She had previously always seemed to come up against limits and to get stuck, and she had frequently ended up in situations with no way out or had had to resort to almost violent methods to free herself. It became clear that the whole way in which she experienced life was determined by this traumatic experience at birth that had not been integrated into

her experience as a whole. It is important to note that it is always the conditions after birth that determine how a very early traumatic experience is dealt with, i.e. whether it can be integrated into the individual's experience as a whole or whether it remains isolated as a result of conflict and tension within the family.

Another patient, a 25-year-old man, "gripped" my attention in our psychoanalytic sessions on account of his incessant talking. In the course of treatment, he became increasingly aware of this, and it was him that thought of the image of him "gripping" me by talking. He realised that the reason for this incessant talking was an irrational fear on his part that I wanted to injure him on the head. When I questioned him about this, it turned out that during his birth he had become stuck and the obstetrician had attempted to rectify the situation by exerting immense pressure on the mother's belly. This pressure was obviously applied directly to the patient's head. In this patient, very detrimental experiences of deficits and loss in early childhood led to the fact that the fear stemming from his birth remained with him in a completely isolated state, like a foreign body, but that at the same time it had an enormous and direct influence and distorting effect on his conscious experiences and behaviour.

In partnerships, too, detrimental pre-speech elements can have a disruptive effect. This became clear from the case of a female patient of mine whose husband had a brief, casual extramarital affair. The patient felt her whole existence threatened and felt insecure in all aspects of her life; she began to panic and became very anxious. She felt her world had fallen apart. This led her to begin psychotherapy. During our sessions, the slightest inattentiveness on my part would lead her to think I was about to throw her out. Conversely, she made a great effort to meet my expectations, thinking this was necessary so that I would not throw her out. It turned out that she had been born in a difficult period during the war and had actually been "forgotten" for a day.

If the other factors concerning a child's development were sufficiently good, such explanations alone can often lead to remarkable improvements in the patient's condition. However, different traumas usually become intertwined and can only be resolved during a relatively long course of psychotherapy. In some cases, the patient's insecurity is such that they are unable to have a relationship. The patients concerned are typically affected by such traumas in the period of change marked by puberty; they protect themselves by simply not becoming involved in a relationship.

This was the case with a 30-year-old woman who came to see me with a severe inferiority complex, depressive moods and apprehension about forthcoming examinations. The first thing I noticed was her stooped posture and her expressionless face. She began the conversation with the remark that she had only come for me to administer euthanasia. She said that she spent her days in isolation in a darkened room and that all she thought about was how she could free herself from this life. She could find no comfort, and she had no hopes for the future. For her, life was one long nightmare, and the world was like a concentration camp. Her actual situation was in fact by no means hopeless or even particularly difficult. She was highly intelligent and had taken two degree courses with great success; however, she had been unable to really identify with any of the subjects she had chosen, and she felt the whole experience of university to be a trap and a dead end

for her and her development. Her destructive attitude towards life was paralysing her and threatening the course of her therapy, which she also regarded as another dead end.

In order to find a way out of this situation, I got in touch with the patient's relatives and had several very moving conversations with her mother, who told me about her pregnancy towards the end of the war, at which time she already had four children and her marriage had begun to break down. An abortion was out of the question for her (and in any case would not have been available), and her existential plight caused her to fall into deep depression.

During the post-war years, the mother managed to re-establish normal family life, and from the outside the development of the family and the children appeared to be unremarkable. In fact, the patient, who had had screaming fits as a baby, seemed almost to want to make up for the trouble she had unwittingly caused, and she became the joy of her mother and of the whole family. The fact that she was good at school also led them to believe that she had overcome the problems of her early life without any lasting ill-effects. During puberty and young adulthood, however, she began to take an increasingly pessimistic view of life, and the above-mentioned feelings of worthlessness and the desire to blot out her own life began to develop; she felt impotent anger towards the world and was unable to find a place in it for herself, let alone start a relationship.

This example highlights the long-term effects of the way in which parents and society treat children in the very early stages of life and the responsibility thus incumbent on them. This sense of responsibility has scarcely become part of our general awareness, a fact which is shown by the readiness to begin wars that is seen in many parts of the world today and that was seen not so long ago here as well. Not only the suffering of children after birth is ignored, but also that of the unborn child. In a statistical study presented in 1968, the psychoanalysts Elisabeth and Theodor Hau showed that children born during the war differ considerably from those born after the war. First of all, the difficulties of wartime life led to "an increased incidence of complaints during pregnancy and problems during birth and during the first few weeks after childbirth". The children had difficulties in making friends and suffered depression from an early age. Elisabeth Hau summarised the results of their research as follows: "During puberty and early adulthood, the children born during the war and immediately after the war were emotionally very unstable and had difficulties in dealing with situations of conflict. They have considerable mood swings, but are usually passive, anxious and quick to retreat. Their relationships with other people remain superficial and they often do not feel at ease in them; they experience the world as cold and as a failure . . . There is an increased incidence of schizoid and depressive characteristics in this group" (Hau 1976, p. 105).

The fundamental significance of being an unwanted child in the way in which individuals later view life and see themselves was established by the the long-term study carried out in Prague by David, Dytrych, Matějček and Schiller (1988) (see also Häsing and Janus 1994). All these findings add weight to the importance of primary prevention.

Possibilities for Prevention

As I have tried to show, in my opinion prenatal psychology has highlighted the fundamental importance of the pre-speech period of life, and in particular the period before, during and immediately after birth. One of the consequences of this is the need for a new way of thinking in terms of prevention on many levels. Up to now, preventive measures deemed necessary and carried out during pregnancy have been exclusively medical ones. The various steps taken in medical antenatal care reflect this development. As a result of the findings of prenatal psychology, these medical steps have been supplemented by psychological and social preventive measures with very far-reaching implications. The purpose of prevention is not merely to avoid traumas that are of significance for individuals in their personal development, but also to avoid collective early traumas, which frequently used to be collective experiences due to pressure on the mother during pregnancy and due to an insensitive approach towards birth and towards children during infancy. An appropriate way of dealing with pregnancy, birth and infancy may have once been instinctively ensured in primates or in early hominids, but during the course of our cultural development, it came to be governed by external difficulties, affective assumptions concerning women and children and a lack of knowledge about the basic needs of infants that is appalling in retrospect. In the words of the American psychohistorian Lloyd DeMause (1979), the history of childhood is a nightmare we are only just waking up from. Perinatal and infant mortality rates were still alarmingly high even at the beginning of this century. Around 1900, due to poor nutrition, the infant mortality rate in Bavaria was 50% (Ottmüller 1991). At a meeting of the Deutsche Psychohistorische Gesellschaft (German Society of Psychohistory) entitled *Psychohistorie und Geschichte der Kindheit* ("Psychohistory and the History of Childhood"), important contributions on this subject were presented (Janus 1995).

The feeling of security at the beginning of a child's life was perhaps once ensured in our phylogenetic history and communicated instinctively; due to the economic, technological, scientific and psychological options available to us, we are now in a position to recreate this security on a new level by dealing with pregnancy and birth and the early parent/child relationship in a conscious and responsible manner. Possible ways of achieving this are demonstrated in other contributions presented at this conference. One of the basic conditions, however, is that society gives young parents-to-be the space for their own individuation in their relationship with the unborn child; despite the many positive developments in the past few years, radical changes are still necessary in this area. Only if parents receive this support are they able to cope psychologically with the individuation process involved in parenthood (Verny 1992; Janus 1995). The results obtained in prenatal psychology suggest that there are undreamt-of opportunities here for individual support (Blum 1993) and ways of making our societies more peaceful (DeMause 1996).

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