Dream Narration in Healthy and At-Risk Pregnancy

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During pregnancy and the transition toward motherhood, a special time for the restructuring of the female identity and representational world, dreaming may play an important function in the psychic life. If we accept that psychological and psychosocial risk factors influence representation during pregnancy, this article explores, from a psychodynamic perspective, how the presence/absence of biological risk is represented into women’s dream narration. Forty dreams of pregnant women (20 healthy pregnancies/20 at risk) were audio-recorded and transcribed verbatim. We performed a thematic analysis of multiple correspondences to see whether the dreams recounted by the women in the 2 different categories had any specific characteristics. Four thematic clusters resulted, which, after interpretation using factorial mapping, fall into 3 sense vectors: from the unrepresentable to the representable; from dependency to reciprocal relationships; from undifferentiated to different. The work we did enabled us to observe that in healthy pregnancies dreams have a mainly elaborative function, whereas when there are risk factors, it seems to be difficult to construct a psychic representational space.

Keywords: dreaming functions, narrative, pregnancy, risk factors

Pregnancy is a period of major restructuring of a woman’s identity and one in which her representational world is transformed with new mental configurations for both the Self and the newborn (Ammaniti, Tambelli, & Odorisio, 2013; Ammaniti et al., 1990; Bydlowski, 2000; Candelori, Pola, & Tambelli, 1990; Vizzziello, Antonioli, Cocci, & Invernizzi, 1993; Fonagy, Steele, & Steele, 1991; Slade, Cohen, Sadler, & Miller, 2009; Stern, 1995).

Pregnancy is a period of psychological gestation that enables women to re-elaborate some of their primal fantasies and to relive, through their bodies, the sense of fusion and separation typical of early relationship experiences, along with some of the more disturbing aspects (Darchis, 2009; Ferraro & Nunziante Cesário, 1985).

As far as sleep and dreams in pregnancy are concerned, the physiology as well as the intensity of sleep changes (Hedman et al., 2002), according to the phases of
pregnancy, for example, there is a decrease in restorative and deep sleep in the first trimester (Lee, 1998; Lee et al., 2000), and dream activity is more frequent (Blake & Reimann, 1993), with a significant increase in the number of dreams, which are more readily accessible to the memory.

From a psychodynamic perspective, changes in sleep patterns that ensure that the body gets enough rest appear to indicate a functional regression on the part of the mother; a biological defense to cope with the tough psycho-physical challenges that pregnancy represents. Hypersomnia is therefore induced by the unconscious perception of the hormonal changes the body is undergoing, and the unconscious activation of a primal identification with the fetus in a dynamic that aims at denial of possible feelings of ambivalence (Soifer, 1977).

An increase in primary-process thinking, which is considered an archaic and primitive thinking linked to unconsciousness, is what specifically characterizes pregnancy, and confirms the hypothesis that the distinctive representative content of a pregnant women’s dreams refers to the pregnancy itself, the baby, her own and the baby’s body. Its function is a kind of “psychological digestion” of the experience (Coo, Milgrom, & Trinder, 2014; Dagan, Lapidot, & Eisenstein, 2001). During the delicate period of pregnancy, dreams can enact negative emotions or feelings of worry, anxiety, or confusion (Backe, 2004). Analysis of dreams recounted by mothers during their first pregnancy, however, tend to exclude high levels of anxiety, thus raising doubts about the idea that pregnancy is a kind of “crisis” period (Bibring, 1959).

Pregnancy and birth are usually experienced as joyful and positive, and this is demonstrated by a recent study that compares dreams during pregnancy and postnatal. The content of the dreams reflected specific aspects of the period before and after the birth, showing how different these stages in the journey toward motherhood are (Coo et al., 2014).

The third term of pregnancy, which is the specific phase that this article focuses on, proved to be the most fertile for dreams, and one marked by a significant increase in a dysphoric-type of sleep, which may contribute to changes in the physiological sleep cycle (Lara-Carrasco et al., 2014). Dreams during this phase are associated with negative content and feelings of fear and terror (Maybruck, 1986), but with no significant differences compared with other stages in the cycle of life (Hedman et al., 2002; Hertz et al., 1992).

**DREAMS, TRAUMA, AND RISK AS DISRUPTER OF NARRATIVE**

Different theoretical perspectives have demonstrated that dreams perform an integrative and elaborative function. Psychoanalysis, which is our field, identifies the conditions that dreams can be deployed in. From *The Interpretation of Dreams* (Freud, 1953) onward, dreams have been understood as the guardians of sleep, allowing for a form of wish-fulfillment that is represented as a hallucinatory experience. In *Introduction to Narcissism* (Freud, 1914), Freud describes a prenatal dream space, stating that “his majesty the baby” was dreamt by the mother and it is this *dream-wish* that will constitute the basis of future primary narcissism. Post-Freudian psychoanalysis demonstrates the epistemological value of dreams as generators of knowledge. Bion (1962) focuses on changes of state, the transforma-
tive processes, from the sensorial nature of images to thought: dreaming and having conscious thoughts are, in fact, similar mental processes, both of which cause changes in alpha function. The alpha function is an abstraction used to describe the capacity of mind to transform the sensorial impressions and emotions into usable data for the construction of dream thought and unconscious waking thinking. The mother’s ability to dream, her rêverie, will contribute to the possible construction of her child’s mental apparatus, laying the foundations for his or her ability to think and dream in the future.

Dreams are an internal poetic language (Meltzer, 1984), an archaic and intimate form of communication rooted in a person’s early affections and communication, especially in the bond between mother and child.

In psychoanalysis, work with dreams allows for the reconstruction of a person’s early affective life, using experiences that cannot be expressed by verbal means alone as the starting point. In this way, past emotions attach to the experience of the transfer, so the session itself becomes like a dream (Ferro, 2009) with the patient and analyst both playing a role in its creation.

Dreams acquire their narrative form in the transition from the emotional experience of a dream to its telling (Bruner, 1990), allowing for the creation of iconic and linguistic symbols on which to base the narrative (Fosshage, 1983; Siegel, 2001). Dreams are not only a psychic act but are also language and narrative. They dramatize and present a person’s inner world, but they are also a type of report that gives structure and form to this world, and, like every good story, they take on new meaning in the telling (Freda, Esposito, & Quaranta, in press; Freda & Martino, 2015; Margherita, 2009; Margherita, Martino, Recano, & Camera, 2014).

Even when dreams are represented as text, they do not necessarily have a narrative structure: they may simply be a set of images that enact unconscious verbal thoughts. By the same token, the recounting of any dream is a text that reflects the structure of the dream but one that enables the teller to improve the organization of the narrative (Kilroe, 2000).

Dreams create connections on the basis of emotions, contextualizing them in a broader and more intense way than when we are awake (Hartmann, 1996). Dreaming performs a para-therapeutic role if we consider that in cases of trauma, dreams enable the victim to create sense links between the terrible event and other things, so that the emotions associated with the trauma start to fade and become less oppressive while the trauma may be partially integrated in the Self (Hartmann, 1995). The conditions for trauma, therefore, are those where psychic elaboration and representation prove impossible and that leads to collapse of the process of construction of meaning, destroying trust in a symbolically shared world (Bohleber, 2007).

Clinic work with dreams and nightmares in traumatized patients, for example, has proved very useful in restoring symbolic function (Hartmann, 1984; Adams-Silvan & Silvan, 1990; Pöstenyi, 1996), where dreams are seen as an attempt at a narrative that lends structure to the traumatic experience, transforming the sense of passiveness of trauma victim into something more active (Varvin, Fischmann, Jovic, Rosenbaum, & Hau, 2013). As a demonstration of this, other studies have shown that dreams associated with previous traumatic experiences include day residues that provoked the same feelings or thoughts as the original trauma, for example feeling of shame or humiliation (Lansky & Bley, 1995). Furthermore, the protective
function of dreaming was also shown in a study carried out on an analysis on dreams of children exposed to severe military trauma; these dreams incorporated more intense and more negative emotional images (Helminen & Punamäki, 2008).

Van, Cage, and Shannon (2004) explored the role of sleep disturbance and dreams in women with a history of miscarriage, highlighting how the traumatic experience is relived and expressed in the content of their dreams.

We know that the quality of representations in pregnancy can influence the future mother–child relationship (Ammaniti et al., 2002; Tambelli, Odorisio, & Lucarelli, 2014; Van den Bergh & Simons, 2009).

Studies on at-risk pregnancies have tended to concentrate on either psychosocial risk or psychological risk; thus on the mental health of the mother. There is a wealth of research on the subject of maternal–fetal attachment and how it evolves, especially in pre- and postnatal depression (Paulson & Bazemore, 2010), taking into account variables such as the nature of the attachment and parenting style. There seem to be far fewer studies that focus on healthy risk factors from a psychological point of view, and whether these are a possible cause of problems with parenting.

In medical terms, risk factors in pregnancy can be associated with pathology in the mother, the so-called “reproductive risk” linked to primary risk factors, which we can then subdivide into localized factors (the reproductive system or previous complications in pregnancy, e.g., a uterine myoma or uterine malformation, previous miscarriages or premature births, a previous stillbirth) and general factors (mother aged under 17 or over 35; hypertension, infectious, hereditary, or autoimmune disease; neoplasia) or with risk to the fetus that only became apparent during the pregnancy (threat of miscarriage, fetal malformation, placenta previa, twins, premature birth, exposure to recreational or pharmaceutical drugs, alcohol, or tobacco).

Within a health promotion perspective, in this work, we place ourselves in line with the World Health Organization and the Istituto Superiore della Sanità (WHO, 2002; ISS, 1998), which consider the diagnosis of risk as a pathology for the women who can influence the course of pregnancy (Evans & O’Brien, 2005; Gupton, Heaman, & Cheung, 2001); medical practices tend to identify the risk as a diagnosis to communicate, sometimes without consideration of psychological implications. For this reason, our aim is to explore how the presence or the absence of risk is represented, starting from the women’s dreams.

When risk factors are present during the pregnancy, the mothers-to-be seem unable to represent Self or their child properly, as if using mechanisms of rationalization or denial they try to defend themselves from a state of profound anguish (Di Vita & Giannone, 2002).

Dreams in pregnancy would seem to be the subject of useful scientific debate, and this article can play its role as few existing studies seem to focus on the dreams of pregnant women when risk factors are present.

If dreams enable us to make sense of mental processes that can kick in after trauma, it is feasible that risk factors during pregnancy could have a specific effect on the production and quality of dreams.

The aim of this study was to compare the dreams of pregnant women in healthy pregnancy with those where risk factors are present, during their third term of pregnancy, a period of high dream production.
Recent literature offers various methodologies for dream analysis that use special techniques to decode the content (Domhoff, 1996; Hall & Van Der Castle, 1966; Schredl, 2002, 2010) that have been used to study different dream corpus. We opted to explore the dreams as text and narrative, using a quantitative-qualitative semiotic analysis (Bolasco, 1999; Lancia, 2004, 2008). Unlike methods based on a content analysis that lead back the themes to predetermined categories, this method is centered on the exploration of the links between the text and its parts.

**METHOD**

**Participants**

The research took place at the Outpatients and Mother and Baby Units in Naples and the Province of Naples during their antenatal classes. The research was approved by the individual Outpatients’ ethics committees, and was carried out over the course of 2012. Our inclusion criteria were as follows: minimum age of 18 and maximum 35; absence of any diagnosed psychiatric conditions; and Italian language speakers. We excluded the following: previous miscarriage; pregnant mothers under the age of 17 and over the age of 35; hypertension; infectious, hereditary and autoimmune diseases; and neoplasias because we wanted the focus to be solely on reproductive system disorders or problems with the fetus.

Of a total of 25 at-risk pregnancies we have selected 20 women; of a total of 30 healthy pregnancies we have selected 20 women. Each group had to fill in an anamnestic form. After informed consent had been given, 40 women in their third term of pregnancy came to a face-to-face meeting. Twenty were at risk (10 primipare, 10 multipare) and 20 healthy (13 primipare and 7 multipare; see Table 1).

**Tools**

After explaining the aims of our research, we gave the women involved a short task to encourage them to narrate the dreams they had when they were pregnant:

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Healthy pregnancy</th>
<th>At-risk pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n = 20$</td>
<td>$n = 20$</td>
</tr>
<tr>
<td>Age, $M (SD)$</td>
<td>28.9 (3.46)</td>
<td>31.3 (2.27)</td>
</tr>
<tr>
<td>Primipare, $n$</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>Multipare, $n$</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Married, $n$</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>Cohabitting, $n$</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Employed, $n$</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Not employed, $n$</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>Risk factor</td>
<td>No</td>
<td>Yes (gestosis/hypertransaminasia, placenta previa/threat of premature birth)</td>
</tr>
</tbody>
</table>
“Recount one of the dreams you had when pregnant.” Aware that one of the methods most used in the literature is the one proposed by Domhoff (The Most Recent Dream Technique; Domhoff, 2003), we have chosen for our study to propose an open task. This choice was the result of the interest to explore as well, within a psychodynamic framework, how the narration of the dream is able to organize (or possibly to deny) any elements of reality (e.g., in the third trimester of pregnancy you know the sex of the child etc.). In our approach the dream narration is different from dream report because the dream narration explores connections, links, and associations that the woman makes on her dream during the narration (Montesarchio & Margherita, 1993; Margherita, 2009).

**Procedure**

We met up with the women when they came in for their normal medical/gynecological check-ups or at the end of their ante-natal class. After giving their informed consent, they were asked to complete an anonymous form with some sociodemographic information. The meeting was led by a psychodynamic psychologist and a researcher.

**Data Analysis**

To analyze the dreams we used T-Lab (Lancia, 2004, 2008), a qualitative-quantitative software for text analysis to identify, based on a comparison of different lexical profiles, the dimensions of meaning and the different themes present in the text under analysis (Bolasco, 1999). We grouped the dream narratives together as one corpus of text. To achieve our aims we did an elementary context unit1 (e.c.u.), and cluster analysis, and used a waterfall analysis to plot these data as active variables on the factorial map using a multiple matching analysis.

The text corpus, amended in this way, was then analyzed. The text is a single corpus characterized by 3592 occurrences, of which 1091 are distinct forms. Forty e.c.u. and 822 lemmas were identified within the corpus.

The two active variables we took into consideration are high-risk pregnancy (yes, no) and pregnancy (primipare, multipare).

**Rationale of Analysis of e.c.u. With T-Lab Software**

The software analyzes the texts as a single set of data (Denzin & Lincoln, 1994), and identifies the choice of lexis, looks at co-occurrence, and performs a comparative analysis. The final product summarizes shared concerns in a few significant thematic clusters (Reinert, 1995) as a contextual field of meanings shared by participants (Reinert, 1995) that allow us to build up “a thread” in the discourse.

1 Sentences, paragraphs, or short texts characterized by the same patterns of keywords.
Lexical units, included in the analysis are the result of a selection process aimed at creating a list of words called “key words.” Each cluster consists of a set of e.c.u. and is described through a set of keywords that, ranked according to the decreasing value of $\chi^2$, indicates that the typicality of each of them within the cluster is associated for semantic value (Lancia, 2004).

This allows us to reflect on and interpret the meaning of individual words by reference to a number of e.c.u. analyzing them in the context in which they are used. The meaning of a word is known only through its relationship with the context, that is, through its distribution within a portion of text (Greimas, 1983; Rastier et al., 2002).

A cluster analysis was then carried out, based on position on the factorial axes, starting with those that were more statistically significant (threshold level $p = .05$). We labeled each cluster and for each one we noted, in decreasing order, the most significant lemmas based on the $\chi^2$ values (see Figure 1).

RESULTS

Factorial mapping of the clusters enables us to observe and interpret the relationships (e.g., opposition or closeness) between the different threads that emerge and understand the factors that link them. We carried out a preliminary analysis of the text using the software tool (see Table 2).

In the left-hand quadrant of the factorial map we find cluster 3 called **Pregnancy as a stage for relationships** (15 e.c.u. of a total of 40, which equals 37.5%). The lemmas identified the following: I (13.253); mother (10.418); blood (9.102); ask (7.79); look (7.56); her (7.56); sit (6.482); bed (3.859); feet (3.859). The variable present for this cluster is *multipare*.

Often I don’t remember my dreams, but the last one I do remember: My baby was born and I went to bed happy but I woke up later and she wasn’t there. I start searching the house for her, and it’s a big house, and every room I go into there’s some relative in there. I try one room after another until I get to my parent’s bedroom and my baby is there in my mother’s arms—she is cuddling her and says “I thought it was better to let you get some sleep.” (SCORE 0.581)

I am holding a baby, I am at home on the sofa and my mum is making us a coffee. The baby is really small, like a mini Tiny Tears, and it can talk already. I’m really surprised by its little voice, so quiet but perfectly comprehensible. I find it a bit strange and ask my mum if she heard the baby talk as well . . . but she doesn’t answer and then she just disappears from the dream. (SCORE 0.508)

In the first right-hand quadrant we find cluster 4 called **The power of doctors when faced with the unknown** (comprising 13 e.c.u. of a total of 40, equal to 32.5%). The associated lemmas are Hospital (20.349); baby (15.731); gynecologist (12.136); physician (12.136); doctor (10.098); way (10.098); reality (4.951).

I had an appointment with my doctor at 14.30 p.m. but it was morning and my husband made me get in the car and he drove me to hospital. The hospital was the one I know—the same blue walls, the same rooms with two or three beds . . . but it was completely deserted. In the hospital I eventually find a male doctor, I remember he was male but I cannot picture his face or

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2 Words or lemmas.
remember how old he was, who wants to examine me. I do not understand and feel confused, especially as I spot my own doctor, a 60-year-old man, in the distance, but then he walks straight past me and pretends not to even recognize me. I feel completely lost, cross and let down, and I start telling my poor husband off and then say that we have to go because we have a doctor’s appointment at 14:30. (SCORE 0.633)

I decide to go to the hospital but once I get there I find out that my own doctor isn’t there. The woman doctor on duty examines me and says that there is nothing more they can do for my baby, and she walks off leaving me on my own. An obstetrician then comes to examine me and his diagnosis is the same—it’s all over. I decide to call my own doctor who says “if that is what they have told you, then you have to come to terms with it.” They come to discharge me and I burst into floods of tears, at which point I wake up, my heart racing I am so upset. (SCORE 0.498)

We find cluster 2 in the lower right-hand quadrant, called Male–Female: from real to fantasy (with 7 e.c.u. of a total of 40, equal to 17.5%). Recurring lemmas are male (44.431); female (44.121); dreams (19.103); memory (12.606); dreaming (8.295); baby (6.994); sister (6.585).

I remember one dream in particular: you could see from the ultrasound that my little boy—it’s always a boy in my dreams even though I am having a girl—had no eyes. I found this dream really upsetting and never told anyone about it. I can’t remember any other dreams, except that the baby was always a boy, even though it’s really a girl. (SCORE 0.590)

<table>
<thead>
<tr>
<th>Table 2. Preliminary Organization of the Text Corpus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lemmatization</td>
</tr>
<tr>
<td>Disambiguation</td>
</tr>
<tr>
<td>Lexicalization</td>
</tr>
<tr>
<td>Cleaning the vocabulary</td>
</tr>
</tbody>
</table>
The lower right-hand quadrant is also where we find cluster 1 called From peaceful to stormy: pregnancy as event (comprising 5 e.c.u. of a total of 40, equal to 12.5%). Birth (35.337); moment (17.24); water (17.24); pregnancy (12.238); dark (11.746); normal (11.746); done (11.746); night (10.24); dream (9.943); sea (8.305); give birth (7.91); eye (4.515); lovely (4.515); time (4.032); new-born (4.032).

When I was first pregnant my dreams were more or less normal, but now that I am coming to the end of the nine months I seem to be dreaming about babies. I can’t remember a specific dream but nearly every night I dream about babies: maybe I am anxious about the birth. The other night I even dreamt that I was about to give birth, or had just given birth, and my baby weighed 12 pounds and had huge feet and I wondered if it was normal. I often dream about children, sometimes a newborn baby, then once a two year-old, and sometimes they are blond, sometimes dark, with blue or brown eyes, maybe I can’t wait to have my baby and see what he or she looks like. (SCORE 0.758)

I dream about the sea, either being in the water or on a boat, often at night but the fact that it is dark isn’t a problem, sometimes I am even on the seabed, and swimming, even if the water is dark and it’s night because I still really like it. And then I often dream about the birth, really often, looking in on myself from the outside when I am about to give birth. I have dreamed about giving birth before but now I dream about watching myself giving birth. Water is always a constant in my dreams though, not only now that I am pregnant, I often dream about water and the sea. (SCORE 0.646)

Analysis of Factorial Axes

Axis I, the horizontal axis, we called unrepresentable to representable. As it can be seen from the diagram, this factor is a continuum with risk factors during a first pregnancy at one end and pregnancy-as-an event clusters at the other. We see this phenomenon in women with low-risk pregnancies. The part of the continuum located in the lower left-hand quadrant is striking for its absence of thematic clusters. We interpret this as an inability to construct a representational space when the pregnancy is at-risk and an expression of difficulties and worries associated particularly with primipare.

The psychic space, therefore, is located within a physical space (right-hand I quadrant in the diagram) characterized by emptiness and absence, by what cannot be expressed or represented or connected to other clusters, and so remains an isolated variable.

The low-risk pregnancy variable, on the other hand, figures as an experience that can be both narrated and represented (as an event).

Factor II, the vertical axis, what we called from dependency to reciprocal relationships shows the opposition between, at one end, the pregnant woman building a new identity based on reciprocal relationships and, at the other, a structured relationship, the woman’s relationship with the medical profession which is seen as “strong” and based on dependency and delegation. On one side, therefore, we have the cluster Pregnancy as a stage for relationships with the variable multipare and, on the other, Medicalization as repository for the unknown with the variable primipare.

On a psychic level, at one end of the spectrum we see recognition of how meaningful relationships change, and a space for the construction of a maternal role and identity, at the other there is a feeling of incompetence that leads the woman to delegate decision-making to other people, who appear in their institutional role.
On the III axis, which we called *undifferentiated to difference*, we find the clusters *pregnancy as a stage for relationships* and *pregnancy as delegator to the medical world* which are at the opposite end of the continuum from *recognition of gender in the unborn child*. The diagram of this three-dimensional factorial map seems, on a psychic level, to summarize and harmonize the different levels involved in pregnancy and the two factors discussed above. This axis, on both a factorial and psychic level, captures the depth and creates harmony with the pregnancy and birth, establishing the common ground between the different aspects implicit in the process. In psychodynamic terms, it is never easy for a mother-to-be to restructure her identity; and it involves identification and differentiation with her own mother first before starting the process of identification and differentiation with her unborn child, through recognition of gender difference and age.

**DISCUSSION**

The Cluster named *Pregnancy as a stage for relationship* illustrates the idea of pregnancy as a period of transition in the cycle of life. In second- or third-time pregnancies, the symbolism in the dreams indicates how the woman is establishing her identity as a mother and learning her role, which is what happens in the narration. The central thematic clusters refer to the experience of change, which can sometimes be disturbing, and the agents for change can even include loss. The lemma “mum” is very dense and polysemic, as can be seen from some of the extracts (the mother, me as a mother).

The woman’s new identity as a mother leads to inner dialogue between herself as mother-to-be and her own mother, who is often idealized as a better version of self. This is an attempt to build a role for herself that is founded on her own strong emotional bonds (especially her relationship with her mother) and teaches her to cope with the necessary, but sometimes scary, idea of being independent.

The dreams show the mother-to-be comparing notes with other women in her family (mother or sisters), as they can be relied on to offer help and support at the vital moment, and provide access to a kind of “instruction manual” that is passed on from one generation to the next.

Dreams enable pregnant women to adjust their own self-image and their values (new maternal values may come into conflict with those of a daughter or a woman), and the object of their love, so that this symbolically pregnant moment is associated with learning a new affective role (Fornari, 1981).

The Cluster named *The power of doctors when faced with unknown* highlights specific but ambivalent references to the places where women go for their pregnancy checks, like the hospital or gynecologist’s clinic. The places are familiar to the women and the figure of their doctor or gynecologist often appears, but in an idealized and almost superhero form, providing the answers and care they need, in stark contrast to other elements in the dream to do with persecution or the anguish of abandonment. The medical institution in the guise of the authoritative male doctor is a place that proves as threatening as it is welcoming.

The Cluster named *Male/Female: from real to fantasy* highlights gender difference and the gender of the future baby. The function of the dream seems to be to elaborate anxiety or expectation. We can see from some of the excerpts that
the women dreamt about their baby and knew whether it was a boy or a girl. Dreams help women come to terms with fear of the unknown and differences between reality and expectation, but also help the mother-to-be identify with her baby on a deeper level. We need to remember that by the third term of pregnancy, women can start to picture what their baby looks like and they probably know whether it is a boy or a girl.

The Cluster named *From peaceful to stormy: pregnancy as event* incorporates things to do with the pregnancy and birth seen as facts or events. They are portrayed as concrete and normal: expected, thought, imagined, and desired but can also be disturbing with references to the dark or night appearing in the dreams.

**CONCLUSION**

Our work confirms our initial hypothesis that when there are complications during pregnancy, women’s dreams reveal special characteristics. More specifically, the dreams of women with at-risk pregnancies, compared with those with healthy pregnancies, seem to present problems establishing meaning links. The women at risk in pregnancy seem unable to think about the risk itself or manage it within a mental space or psychic product like a dream. This is more the case of primipare, because, compared with multipare, it is the first experience of motherhood and probably it is more difficult to deal with uncertain aspects of pregnancy.

The findings of this study have a number of implications. The experience of recounting a dream, in a special setting, provides a valuable opportunity for constructing meaning, whether there are complications with the pregnancy or not, and for elaborating some of the worries normally associated with the approaching birth. A comfortable atmosphere was created for our research-interviews and the women were all very willing to share their emotional experiences and the presence of a listener gave the women the opportunity to transform their dreams into stories, and gave credence to the clinical relevance of the project especially in cases of vulnerability or risk.

From a psychodynamic point of view, dreams during pregnancy are part of a reciprocal matrix, based on the idea that the baby’s psyche reveals traces of the mother’s dreams. Future research could focus on the effect of these dreams on the baby’s psyche.

From a neuropsychological standpoint, new technologies are coming ever closer to exploring fetal dream activity. The 4D ultrasounds, combining the three-dimensional ultrasound images adding the dimension of time to the process, already enable us to watch the fetus in vivo, and to see how they gesture and express emotions (Kurjak et al., 2013; Talić et al., 2011; Kurjak et al., 2010; Mišković et al., 2010), providing a series of diagnostic parameters to identify eventual complications and also to infer aspects of the psychic state and development of the baby and indications of its early relationship with his mother.

The methodology we used in our research took us from the language of words to the language of images, whereas recounting the emotional experience of a dream does the opposite, moving from images to text. In this sense, this work on dream narration and analysis can offer pointers in the clinical field for prevention and
diagnosis, for example using the emerging dream data as precursors of psychological disease (Morgenthaler, 1986).

In our research field, this would be strengthened through the combination of assessment tools for the symptoms psychological assessment, relevant in high-risk conditions (e.g., anxiety, depression, etc.), even in the post-partum (e.g., EPDS Edinburgh postnatal depression scale, Cox, Holden, & Sagovsky, 1987). We are aware that this is a limitation for this study; we aim to integrate the psychological evaluation with the aspects related to medical risk.

For further research we would like to enlarge our group of women and study the different function that the dreams assume in different risk conditions (e.g., the previous miscarriage).

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