Fantasy State During Pregnancy: A Psychoanalytic Account

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Full Text: Headnote ABSTRACT: Fantasy during pregnancy is a very common occurrence, especially during the third trimester. It is often disturbing to the woman, and may provide insights into client concerns of clinical relevance to the health care professional who delivers care to this population. This paper reports on a preliminary classification schema for third trimester fantasies, based on a survey of fantasies reported by pregnant women during this time period. Clinical examples of counseling situations using the schema to identify pregnant clients' problems and concerns are discussed. Assessment of fantasy state during pregnancy is seen as one important component to be included in delivery of care to the whole woman. As a concept of interest in health care and health care delivery, fantasy has been largely ignored. However, it continues to play a prominent role in the various schools of psychoanalysis from which come many theoretical speculations concerning prenatal life. Recently, health care professionals, in particular, nurses, have begun to be interested in fantasy as an indicator of health (Blair, 1987, Sherwen, 1987, Sherwen, 1986, Lederman, 1984, Sherwen, 1981) and to evolve qualitative and quantitative measurement tools to observe fantasy state in humans. In particular, pregnancy appears to be a state in humans when fantasy performs important functions for the woman, and her evolving relationship with the fetus and infant-to-be (Winestine, 1989, Notman, Lester, 1988, Rubin, 1984, Lederman, 1984). This paper concerns the state of fantasy production during pregnancy. Many classic theorists indicate that fantasy pattern is actually altered during pregnancy. Deutch (1965) believed that feminine anatomy directly affected a woman's fantasy, which, during pregnancy, was said to help her become more and more passive in awaiting motherhood. Benedek (1970) saw fantasy influencing the emotional course of pregnancy and therefore the mother's attitude toward the child. The future mother-child relationship might depend on the woman identifying with and fantasizing about the fetus as the "loving and loved self," a state fortunate for both mother and fetus. Alternatively, she might see the fetus as the "bad, aggressive, devouring self and fantasize about carrying a monster, resulting in panic or depression. Such fantasies augur poorly for the evolving mother-child relationship. Similar to Benedek, Caplan (1959) based formulations concerning fantasy during pregnancy on his clinical observations. He also believed that future relations of the mother to her child are a direct continuation of the mother's relation to her fetus and are mirrored in fantasy content. Caplan believed that the first important aspect of infant-to-be representation in fantasy was the age of the fantasized infant. He held that the best maternal-child relationship would result if the mother fantasized the baby as a little baby, and that day dreams of a young infant were positively emotionally toned. Caplan had found that women who only dream of older children often fear the very young infant as an uncontrollable bundle of instincts. Another important aspect in pregnant fantasies, to Caplan, was the fantasized sex of the infant. If the mother fantasized infants of both sexes and was indifferent to the sex of her fetus, a positive motherchild relationship was postulated. If the mother consistently fantasized about one sex in the infant, a possible conflict in the maternal-child relationship might be anticipated. More descriptive information of fantasies in pregnancy came from the clinical observations of Rubin (1972, 1984), who found a discernible fantasy pattern as the pregnancy progressed. Early in pregnancy there were fewer fantasies than there were later on in the pregnancy. In the first trimester, fantasies about the child seemed to stem from outside stimuli, often symbolically linked to pregnancy, such as an egg. During the second and third trimesters, fantasies were more specifically related to what the child would be like when it arrived, and were rich and vivid in content. These fantasies, Rubin believed, serve the important function for the woman of physical and psychological "binding-in" to the idea of having her own

child. They served to orient her toward the child in the future: its sex, appearance, and personality. Rubin found that, in general, during the second trimester, fantasies about the sex of the child tended to be of infants of either sex. In the third trimester, the sex of the child in fantasy tended to be female. Concerning the age of the fantasized child, Rubin held that the child was always of a size larger than a newborn infant. In mid-pregnancy, the woman tended to fantasize a child in situations of her own recent wished-for adolescent past. This was followed by fantasies of a young, preschool-age child. The smallest-sized child a woman was able to fantasize, according to Rubin, was a child about six months size. The expectant mother is said to be unprepared through fantasy for a very small infant at birth. Rubin (1972, 1984) also collected other descriptive information about the infant. In pregnant women's fantasies, the child was seen as occupying a space only through movement and as having a floating evanescent, "impermanent" quality. Finally, Rubin described fears during pregnancy as they were manifest in fantasy, which she saw as very unpleasant and troublesome. Fantasy in the third trimester was influenced by the imminence of labor, the burdensomeness of the enlarged body, and the sense of decreasing control over the body and its vulnerability. Fantasies at this time were of a hairy, animal-like child or of a dismembered or grossly incomplete child. As labor became more imminent, there were increasing fantasies of the woman herself being in dangerous and destructive situations. Rubin saw daydreams and night dreams as being continuous processes, both reflecting changes manifest by the developing stages of pregnancy. FANTASY AND ACCEPTANCE OF THE MATERNAL ROLE Fantasy also performs some vital functions for the pregnant woman. Several investigators from the field of nursing have pointed to the role played by fantasy in facilitating the expectant woman's acceptance of the maternal role. According to both Rubin (1984) and Lederman (1984), fantasy is a vital process necessary for assuming the maternal role and also for acceptance of the pregnancy in general. Thus, fantasy needs to be assessed for delivery of care by nurses or other health professionals. Rubin sees fantasy as one of the necessary phases a woman passes through in the process of attaining a maternal identity. Fantasy marks the beginning of "internalization" of the maternal role, whereby the expectant mother, through imagery, projects how it will be to mother a child in the future. To Rubin, "fantasies are instrumental in the binding-in ... to self as mother" (p. 30). Rubin also sees fantasy as a necessary component in resolving grief for loss of the past life and for the roles a woman must give up. Fantasy allows a woman to review her past in memory and recognize that these past stages are irreversibly finished. Lederman (1984) sees fantasy as a major form of preparation for motherhood. This preparation occurs in three initial steps: 1. Envisioning oneself as mother 2. Thinking about those characteristics one wishes to have as a mother 3. Anticipating future life changes that will be necessary Lederman sees night dreaming as a process not sharply differentiated from fantasy. In Lederman's subjects, reported dream content tended to parallel actual waking concerns. Five categories of dreams commonly occurred: school dreams, reliving childhood, motherhood/career conflicts, confidence in maternal skills, and food/infant intactness dreams. These themes pointed to areas that must be resolved by the pregnant woman in order for her to accept her pregnancy and move into the maternal role. FANTASY AND PROBLEM SOLVING DURING PREGNANCY Several theoreticians and investigators have pointed to the role of fantasy in helping the pregnant woman to solve potential crises in her current and future life (Schuker, 1987, Zeanah, Keener, Anders, 1986). Levy and McGee (1975) looked at crisis resolution through fantasy production as an attribute that might affect the individual during labor. These investigators, defining labor and delivery as a crisis, attempted to study the woman's ability to resolve crisis in fantasy, plus attitudes concerning childbirth inherited from her own mother, as determinants of a positive childbirth experience. Levy and McGee based their work on the theory that fear arousal in certain amounts has a "psychological inoculation" effect that will enable the individual to understand and deal with the stressful event better by imagining the event and resolving it in fantasy. Thus, those pregnant women, especially primigravidas, exposed to moderate descriptions of labor and delivery from their mothers, will deal better with their own labor and delivery than women receiving no information concerning labor and delivery, or women receiving either very positive or negative descriptions of labor and delivery. With a normal moderate

exposure to realistic labor and delivery fears, the woman can do the "work of worry" through fantasy production and have an imaginative rehearsal concerning labor and delivery. She will be able, through fantasy, to envision the possible outcomes of her labor and delivery. In her imaginings, she will be able to solve a variety of problems and devise solutions to alternative outcomes of the labor and delivery process. For example, she will be able to imagine a labor where she has fetal monitoring, including how she will act; or she may imagine a labor that is truly controlled by use of Lamaze techniques. If communications concerning this process are absent or of a very positive nature, the woman will tend to deny the stressful situations and will be at a disadvantage when faced with the crisis of labor and delivery. She will be unable to imagine anything but a "perfect" labor and delivery. If communications are too negative, the woman will be immobilized and too fearful for a realistic imaginative appraisal of her labor. Levy and McGee found that these conjectures held under experimental conditions with a sample of 60 primagravidas. Thus, it seems necessary for fantasy, with its components of imaginative rehearsal and problem solving, to be encouraged during pregnancy. A SCHEMA FOR CLASSIFYING FANTASIES DURING PREGNANCY Although surveys and research have added greatly to the theory of fantasy during pregnancy, fantasy has not been seen as a basis for health care intervention in a systematic manner. One important outcome of the study of fantasy in pregnancy would be development of a categorization or schema that would aid the provider in counseling the pregnant client. In 1980, Sherwen did a survey of fantasies experienced by pregnant women in their third trimester (Sherwen, 1980, Sherwen, 1981). In addition to responding to the experimental questionnaires, volunteers were asked to record any night dreams or daydreams they had during the testing interval (approximately five weeks). Day and night dreams are considered as variants of the same state of mentation and so both forms of fantasy production were considered necessary here (Singer, 1975, Clinger, 1971). Although a total of 153 pregnant women were included in the larger experimental study, the third trimester fantasy study was begun after approximately one-third of the large study's sample of women had been tested with the experimental questionnaire. This survey of fantasies was in response to spontaneous requests made by the subjects to record their night dreams and daydreams and discuss them with the investigator during the home visits made to collect data. Subjects seemed to perceive discussion of and support about their fantasies as important to their total well being. Of the approximately 100 third-trimester primagravidas surveyed, 50 recorded at least one day or night dream. The total of recorded fantasies was 89. The 50 individuals were between the ages of 20 and 30, of mixed race and ethnic background, and of middle-class socioeconomic status. The fantasies were subject to content analysis, and were categorized. It was possible to develop a classification schema of third-trimester fantasies based on the following principles: 1. The content of the day and night dream. This might give clues as to the current concerns of the pregnant woman. 2. Verbal and nonverbal communications of the pregnant woman during the discussion of the day or night dream. This might give insight into the affective state or feeling tone the woman has concerning the dream. A woman might communicate positive or negative feelings about a particular fantasy. 3. Verification by the pregnant woman concerning the current concerns that might be the basis of fantasy, and how she feels about them. The classification schema that was developed from these principles is summarized in Table 1 (Sherwen, 1987). Such a classification schema is incomplete and needs further verification from additional studies of fantasy state in pregnancy. In addition, it deals only with thirdtrimester fantasies, which while they are the most vivid and disturbing of all fantasies produced during pregnancy, are certainly not representative of fantasy state during pregnancy as a whole. The following section will discuss in more depth each category of the schema, and highlight the discussions with examples of fantasies representative of that category. A final section will suggest a model for intervention with the pregnant client based on the fantasy schema.

TABLE 1
Classification of Third-Trimester Fantasies

Content	*Affect (feeling tone)*
1. Everyday fantasies (38%) of fantasies. **Examples:**	
a. Characteristics of infant-to-be (sex, looks, hair, eyes); baby at different stages of growth and development; living with and caring for baby (playing, feeding, loving)	Positive
b. Reaction of husband, significant others, to infant	Pos. and/or neg.
2. Being attacked (mother or symbol) (21% of fantasies). **Examples:** Burglar stealing; intruders in house; falling downstairs	Negative
3. Giving birth to an "abnormal" infant (12% of fantasies). **Examples:**	
a. Misshapen or deformed; abnormal size, age, or ability	Negative
b. Multiple infants (usually twins)	Positive
4. Restoration (11% of fantasies). **Examples:** Death (resolve past deaths, complete intergenerational cycle); reparation (make amends with family, friends)	Positive
5. Sexuality (8% of fantasies). **Examples:**	
a. Sexual relations with husband, mate	Positive
b. Sexual relations with others (father-in-law, obstetrician)	Negative
6. Being inside; drowning (5% of fantasies). **Examples:** Subway tunnels; sinking in lake of slush	Negative
7. Losing or forgetting (2.5% of fantasies). **Examples:** Baby, others	Negative
8. Being unprepared (2.5% of fantasies). **Examples:** Exams, labor	Negative
9. Symbols frequently found. **Examples:**	
a. Water (lakes, ocean, rivers, rain, swimming pools, drinks)	Pos. and/or neg.
b. Stairs, especially spiral	Negative
c. Animals (baby animals, pets; often in threatening situations)	Negative
d. Bright or drab colors	Neg. and/or pos.

n = 89 recorded fantasies

Categories of Third Trimester Maternal Fantasies The following eight categories represent fantasies reported by primagravidas during the third trimester of pregnancy. Fantasies About Having Abnormal Infant This theme is one of the most common found among the fantasies of the third trimester and has been widely reported in the literature. Many of the women interviewed reported having dreams with this theme. These dreams generally included having a deformed infant; having multiple infants; and having delivery complications which affect the infant. Good example of such night dreams are: "About a week ago, I dreamed that we had a new born baby girl who could already talk, and she never wet her diapers; she had a funny nose that had to be filled out, kind of like a balloon." "I dreamt that I gave birth to a large girl in a very few minutes of labor. She was the size of a ten-year-old child! I was upset because I had no baby to hold!" As might be expected, most of these fantasies were accompanied by fear, anxiety, or other unpleasant emotions; and frequently were viewed as premonitions by the pregnant individuals. Only the fantasies of having a multiple birth-usually twins-were associated with positive, happy feelings. Fantasies About Being Attacked- In these common fantasies the mother, or a symbol, is attacked. For example, some individuals dream of pets being attacked by larger animals, or of intruders or burglars violating their dwelling. Sometimes other unknown people are the targets of these attacks: "I was in the labor room with about five other women. We all have our babies with us. I saw tiny, tiny red bugs crawling in bunches all over the women and babies. I woke up frightened and itching all over." A frequent fantasy in this category is of falling down stairs either after a push or a slip. In fact, one repeated symbol emerging from many dreams is that of a spiral staircase. In these fantasies there are negative feelings and they seem to be the most disturbing and troublesome of all the day or night dreams described. Fantasies About Being Enclosed or Drowning: A fewer number of women described night dreams dealing with being inside enclosures: tunnels, cars, little rooms, and so on. In some of the fantasies, the pregnant women were unable to escape: "I dreamt that my husband and I were in his car about to go through a car wash. For some reason, my husband got out of

the car and I went through the car wash alone. At the end of the car wash, the car, with me inside, dropped off into a deep lake of snowy slush. I spent the rest of the dream trying to figure out how to get out of the car without drowning, freezing to death, or suffocating. I awake before I was killed or saved." Fantasies About Forgetting or Losing Things: During the last trimester of pregnancy, women frequently recount unpleasant fantasies about losing objects or people who are in some way attached to them significantly. Thus, the mothers will be subject to feelings of guilt, usually unfounded. Both the dream and the attacks of guilt tend to be recurring throughout this period. They usually take the following form: "I was doing routine things and forgetting about the baby. Or I'll go out and then remember the baby." Fantasies About Being Unprepared: Several of the pregnant women described another type of recurring fantasy-that of being unprepared for labor, either in symbolic form or directly stated: "I had recurring dreams of not being prepared for final exams at college and high school. I felt panic because I had done no work all semester." Fantasies About Sexual Encounters: These fantasies can evoke positive or negative emotions. The key to which emotion is aroused seems to be the perceived legitimacy of the fantasized mate. For example fantasies about sexual encounters with a husband seems to be a great source of pleasure for the pregnant woman: "I dreamt my husband and I made love very, very slowly on a waterbed that moved back and forth, side to side." On the other hand, fantasies about sexual encounters with an individual perceived as taboo for the pregnant woman-such as old boyfriends, male obstetricians, or male relatives-can produce great guilt: "I dreamt I was making love to my father-in-law, and my mother-in-law found out. She was angry and ashamed of me." Fantasies About Restoration: These fantasies are unusual because they deal primarily with death, and yet, they are accompanied by positive feelings. A large number of the women interviewed talked about these fantasies. Gerald Caplan (1959) believes that the woman, during the pregnancy, has an opportunity to rework and resolve old crises. The pregnant woman who reports having this type of fantasy seems to be resolving a loss of someone close to her. Even more striking, there seems to be link between the generations-from the infant-to-be to the ancestors. Thus, these women seem to be restoring the family chain which has been sundered by death; they are adding another link to the chain with a new baby. The following is an example of a fantasy depicting this link-up: "I had one dream in which I was pushing my new-born baby in a baby carriage. I passed large groups of people sitting on long, long benches. One of these people was an uncle of mine who had died two years ago. He winked and smiled at me. The overall feeling was happy, but also rather anxious and tense ..." Another primigravida had lost a younger brother previous to her pregnancy and dreamt about him: "I dreamt about my brother learning to have fun in camp. I knew he was going to die-but he was having fun in the pool with his instructor and it didn't bother me." Everyday Fantasies: Nearly one-half of the women I interviewed described at least one day or night dream that could be included in this category. In general, these fantasies deal with real concerns, plans, and problems any family having a new baby would have. Some common themes were: life changes and restructuring living space and time for the new baby; characteristics of the infant-to-be, for example, sex, health, looks, hair or eye color, beauty, or family resemblances; strategies for coping with labor; checklists of chores for preparation; living with and caring for the infant-to-be, for example, living, playing with, or feeding the baby; reactions of the father or others of importance to the baby; the mother-to-be's own childhood experience; and the baby in different stages of growth and development. As Rubin and others have pointed out, such fantasies might serve as mechanisms for "binding" the infant to the mother and family. Further, Klaus and Kennell also have pointed out the potential functions of these fantasies in the overall "bonding" process (Klaus, Kennell, 1982). Third-Trimester Fantasy Work and Interventions Although somewhat premature at this point, this classification schema might give a framework for conceptualizing third-trimester fantasies and for aiding interventions by nurse, prenatal educators, counselors, midwives, and medical care providers based upon assessment and diagnosis of the concerns expressed by the pregnant client. Interventions in response to fantasy assessment can be seen as a form of primary level health care intervention. In this light, both positive trends (such as problem-solving fantasies) and problem trends (such as decrease in bonding fantasies) can be identified and either supported or altered. The

following are some preliminary examples of the ways in which clinicians have intervened in these areas (Sherwen, 1987). Such techniques need further verification through quantitative and qualitative investigations. Supporting and Enhancing Positive Fantasies: The health care provider can support and enhance trends toward positive fantasy responses to pregnancy, labor and delivery. The example of the fantasy described in the "being enclosed and drowning" category is one whose content might be supported by the provider. Although basically quite a negative fantasy, this night dream demonstrates one very positive trend in the primigravida's repertoire for dealing with her pregnancy and impending labor. Even though she is literally all alone in her dream, abandoned by her husband and "drowning" in a lake of slush, she sees herself dealing with the situation in a calm, problem-solving manner. The feeling associated with the dream is not totally negative, as the tone is hopeful, one of "solving problems." In a counseling situation, it would be vital to support this woman's use of a problem-solving attitude in dealing with the aspects of labor and delivery that frighten her. In this case, specific suggestions of how to solve to the possible problem of getting her husband in a more supportive role were explored, such as mutual involvement in parenting classes and preparation activities for the infant-to-be. It was suggested that she and her husband enroll in a Lamaze or other childbirth preparation class, and she was given reading lists concerning the process of labor and delivery. These interventions supported this primigravida's striving to solve problems in an independent manner. Ameliorating Excessive Negativity or Fear The health care provider can reduce the impact of excessively negative or unrealistically frightening fantasies by "defusing" a frightening fantasy situation and by supplying realistic information about a situation or impending event. "Frightened" fantasies in the pregnant woman can be handled on several levels. First, it is important to remember that all negative-toned fantasies are not "bad." Fantasies that deal realistically with potential problems in pregnancy, labor, and delivery, and with the infant-to-be, are actually beneficial for the pregnant woman. It has been found that women who imaginatively rehearse how they would handle potential problems in the upcoming events, for example, having a caesarean delivery, actually handle all events better than women who have had only positive fantasies about the infant and the labor and delivery experience. Fantasy production that is too positive or too negative can leave the parturient unprepared for the real event of labor and delivery, and for caring for a newborn (Levy and McGee, 1975). Fantasies in the "being attacked" or "abnormal infant" categories in the schema can provide examples of how to intervene to prevent potential problems resulting from too negative a fantasy state. The first technique is to ascertain the actual area of concern, since many fantasies utilize symbols instead of direct representation of the event. When the concern is identified, it can be "defused" by discussing it with the pregnant woman in realistic terms. At this point, the second technique is used-supplying realistic information about the situation or event and allowing the woman to resolve her fear in her own manner. For example, one primigravida had this night dream from the "being attacked" category: "a vampire was attacking many people at random. I was not in any immediate danger. All I could do was watch . . ." This fantasy had a highly negative tone and uses symbols. The theme was definitely one of being "attacked" and "drained" by something evil. Distancing mechanisms were used, since others, not the primigravida herself, were being attacked and she was not in "immediate danger." However, a sense of being helpless in the situation was also implied, since she could only watch. Thus, the associated feeling was negative. Upon discussion, it became evident that this primigravida's concern was the potentially intrusive procedures that might be done during labor and delivery (that is the enema, episiotomy, and internal examinations) and her feelings of being unable to protect herself from them. Identification and discussion of the fearful situations helped to defuse her fears. The primigravida was then ready for the second phase: being supplied with realistic information about the events she feared. The procedures that might be done and the rationale for doing each were discussed in depth. Pros and cons of each intrusive procedure were weighed by the woman, with the provider as an information source and sounding board. This primigravida, after understanding the procedures, resolved her fears by deciding to discuss with her obstetrician her wishes not to have an enema or an episiotomy unless absolutely necessary. Observing the Progress of "Bonding" Clues in Fantasy Rubin (1984)

and others have pointed to fantasies about the infant-to-be and caring for the baby as important to the process of "binding-in" the infant to the mother and family. The fantasy production in the "everyday fantasy" category provides a measure of the progress of the bonding process before the actual birth of the infant. Here, the most important observation to make in problem prevention would be the suppression of these fantasies. Inability to fantasize at all about the infant-including the possible sex and other characteristics, as well as nurturing the baby-is one important clue to a potential "bonding risk." For example, one primigravida in her eight month of pregnancy who was being cared for by nursing students supervised by the author, repeatedly referred to her infant-to-be as "it." The woman further refused to imagine how she would care for the infant and verbalized an inability to picture her child and a lack of interest in whether her child would be a boy or girl. Her nonverbal communications were overtly hostile when queried on her impending motherhood, and she said that she "couldn't imagine herself being the mother of a crying kid." At this point, it would be vital to look for potential blocks to attachment, such as unresolved grief or loss, marital instability, role ambivalence, and so forth. In this woman's case, an examination of her family history revealed that she had been abandoned early in the pregnancy by the father of the infant-to-be. If a tangible block can be discovered, the health care provider can intervene to resolve this crisis situation, or, if the problem is too complex to deal with, the provider can refer the client to a specialist. However, identification of the potential problem through fantasy production and support through more intense intervention is the responsibility of every provider involved with prenatal care. No women included in the previous mentioned survey were actually repressing "everyday fantasies." Encouraging Preparation for Childbirth The health care provider can identify and supply, through analysis of fantasy, appropriate education and other help for the client in her preparatory activities. This form of intervention is similar to that used to work with someone with a frightening fantasy, but it does not require the "defusing" phase. There were several fantasies identified that were not frightening per se but spoke specifically to the parturient's not being ready for the upcoming events. These fantasies had associated feelings that were definitely negatively toned and thus required intervention. An example of this type of fantasy is described in the "being unprepared" category of the schema above. In this fantasy, symbolism was used, but the overall thrust was unmistakably "not being prepared," while the associated feeling tone was negative. Intervention was simple for this primigravida. After discussing her concern about being ready for labor and delivery, her plans to take childbirth preparation classes were examined. She concluded, with support, that childbirth preparation classes were an important mechanism to prepare her for the event, especially since they would give her actual "work" to do in preparation (that is, reading and practicing the exercises). In addition, several books and pamphlets that would help her begin her preparation process and give her work in the present were suggested. Alleviating Guilt Feelings Guilt feelings generally fall into two types: sexual encounters and ambivalent feelings concerning the infant. It was mentioned that fantasies falling into the "sexual encounter" category are of two basic kinds: those fantasies dealing with a sexual encounter with a person who is perceived by the pregnant woman as legitimate, and those fantasies dealing with a person perceived as not legitimate. While both types of fantasy deal with sex, the first variety of sexual fantasy seems to have a highly positive affective tone and is a source of pleasure to the pregnant woman. The second type, however, is problematic, since the pregnant woman usually feels guilty for fantasizing a sexual relation with someone perceived as socially unacceptable. In this case, the associated feeling tone is negative. Counseling in this instance deals with the alleviation of guilt, since sexual fantasies, especially night dreams, are quite common to pregnant women. Helping the woman to realize that her dreams are not abnormal and that she is not alone in having such fantasies while pregnant is often sufficient to alleviate associated guilt. Fantasies from another category in the schema, "losing/forgetting," also seemed to induce guilt feelings in the pregnant woman. These fantasies, usually night dreams, had themes about losing or forgetting the infant-to-be. The following is an example of one primigravida's night dream: "... doing routine activities and forgetting about the baby; I go out and then remember that I've left the baby somewhere .. ." This woman, when the dream was discussed, expressed some minor ambivalence, not so much about the baby, but of her

impending role of "mother." She was reassured that this was a common concern of expectant mothers, and coping strategies for parents of newborns and the possibility of her joining a new parents' group were discussed. This proved to be a successful intervention. Supporting "Restoration" Efforts Interventions based on fantasies in the final category to be discussed, "restoration," are supportive in nature, since the trend revealed in these day and night dreams seems to be highly positive. Of the 50 individuals recording day and night dreams, 11% had fantasies falling in this category. As Caplan (1959) believed, it would seem that the woman had a chance during pregnancy to rework old crises, and, as it were, make her intergenerational pattern complete. These women had fantasies about dead and lost friends and relatives and seemed to resolve or repair the loss through the impending birth of the infant. The process was almost like a generational "linking-up" of the infant-to-be with ancestors. A like process allowed the pregnant woman to resolve death of loved ones. Since fantasies described in the category were useful and seemed to have a very positive tone, women were supported in the further exploration of feelings and experiences associated with the fantasies. This type of fantasy may well be an important mechanism for resolving unfinished grieving processes connected with death and loss, and for binding the infant into the total extended and lineal family system. SUMMARY The foregoing discussion of a preliminary schema for categorizing fantasies during pregnancy and planning interventions based on fantasy assessment may be a useful addition to care delivered to the pregnant client during the prenatal period. As with many other types of assessment, it requires further documentation of its benefits and is only justified when taken in concert with other areas of assessment and put into the context of the whole. However, fantasy in pregnancy is something obvious and often disturbing to the pregnant woman. It cannot therefore be ignored by health care providers who wish to care for the whole individual during pregnancy.

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