On Trauma—When is the Death of a Parent Traumatic?

Erna Furman

AS MY CONTRIBUTION TO THE PANEL ON TRAUMA REVISITED (E. Furman, 1984), I was asked to discuss the potentially traumatic effects of parental bereavement in childhood. This assignment gave me the opportunity to trace again, for myself, the history of the term trauma as an analytic concept, to review the material gained from the treatments of traumatized children, both my own cases and those of my Cleveland colleagues, and to formulate some thoughts as well as questions about the topic. Although I shall limit the case examples and most of the discussion to children who had lost a parent through death, my thinking is also based on data derived from the analytic study of other traumatic experiences, such as sexual and aggressive abuse, life-threatening accidents, illness, injury, and medical/surgical procedures.

WHAT IS A TRAUMA?

In analytic papers the term "trauma" is frequently used in the sense of connoting a severe stress, and a child's parental bereavement is commonly referred to as a traumatic experience. I do not wish to minimize the crucial importance for a child of his bereavement as the potential cause of trauma. We can never say before treatment that the death of the parent as such was traumatic. The later case vignettes will illustrate that, in each instance, different combinations of internal and external factors proved to have been traumatogenic—the circumstances of the death, the incapacitation of the ego through bodily injury at the time of loss, the antecedent experiences, existing ego mechanisms and instinctual impulses, the role of the environment, developmental factors, and many more.

Irrespective of the varied individual causes of trauma, however, its immediate effect on the organism is always the same. The ego and pleasure principle are put out of action when the psychic system is either altogether overwhelmed by the excess of excitation or cannot prevent the pouring in of stimuli through a limited breach in its protective shield. In the case of total flooding, all ego functions are suspended, the entire defense organization which served as the protective shield becomes inoperative, and the organism is left with no defense against the overwhelming influx of excitation.
mental apparatus is reduced to what A. Freud (p. 238) calls "physical responses via the vegetative nervous system taking the place of psychic reactions," or what Yorke et al. (1980) term "vegetative excitement" which may behaviorally resemble a temper tantrum. In the case of a breach in the protective shield, the repairation process, according to Freud (1920), begins at once by a massive anticathexis which drains off all the available energy and extensively reduces or paralyzes the remaining functions. This manifests itself in states of shock (Freud), in states of paralysis of action and/or numbness of feeling (A. Freud), in battle exhaustion (Yorke, et al.), in some types of apathy (Greenson, 1949); (E. Furman, 1974), and in some forms of depersonalization.

These traumatic or immediately posttraumatic states may last for minutes, hours, days, months, or years. They may recur, even recur repeatedly under certain conditions, a point I shall return to. When we can actually observe these states in patients, they can serve as one indication that the patient experienced a trauma. However, since these states sometimes last only for brief periods and since both the patient and others may not notice them or may misinterpret them, such observations are often omitted from the personal history and from reports on current behavior. Moreover, even professionals find it hard to differentiate posttraumatic states from other disturbances, especially in prelatency children. I know of two cases misdiagnosed as "minimal brain damage and retardation" and several others termed "psychotic" (E. Furman, 1956).

**THE PROCESS OF RECOVERY**

After the catastrophic event, the psychic apparatus is faced with the problem of binding, or mastering, the noxious excess of stimuli and of restoring all areas of ego functioning and their phase-appropriate maturational progression.

According to Freud (1920), the gradual process of binding takes the form of repetition compulsion until all stimuli have been mastered and brought under the domain of the pleasure and/or reality principle. Among manifestations of this process Freud includes certain forms of children's demands for repetition and passive into active play, repetitive dreams, fate neuroses, and analytic transference phenomena. Yorke et al. (1980) further include children's pavor nocturnus and stage IV nightmares and their accompanying motoric discharges.

A. Freud (1964) points out that we should differentiate between two types of repetition. One is a pre-ego process, i.e., the repetition compulsion; the other is an ego mechanism "repeating an experience with variations suitable for its assimilation, such as turning a passive experience into an active one" (p. 237) or employing defenses such as denial. Such a transition from pre-ego mechanisms to ego mechanisms indicates a progression in the recuperative process.

Another measure of the nature and rate of recovery mentioned by A. Freud is the reemergence of ego functions—either residual or reinvested—and how fast or slowly they reach their pretraumatic level and pick up their phase-appropriate maturational momentum.

The nature and role of anxiety are other important elements in our understanding of trauma and of posttraumatic developments. Freud relates the failure of signal anxiety, and aspect of the system's preparedness, to the occurrence of trauma and views the need to repeat as an endeavor "to master the stimulus retrospectively, by developing the anxiety whose omission was the cause of the traumatic neurosis" (p. 32). Yorke and Wiseberg (1976) and Yorke et al. (1980) trace the developmental line of anxiety from vegetative excitation which is bodily, to terror/panic which is primitive mental, to signal anxiety. Winnicott emphasizes two further stages in the development of anxiety which follow the purely vegetative excitement and precede the essentially mental terror/panic. Both of these anxiety states combine mental and bodily responses. The first (Winnicott, 1960a), (1963c), the developmentally earlier one, happens when the traumatic impingement awakens the ego's awareness to experience an interruption of its "going-on-being" (1963c, p. 256). The second, later one is characterized by annihilation anxiety or "unthinkable anxiety." Its contents are "(1) Going to pieces. (2) Falling for ever. (3) Having no relationship to the body. (4) Having no orientation" (1962, p. 58). I am uncertain as to the developmental point in earliest infancy when vegetative excitement begins to be accompanied by the mental experience of an interruption in "going-on-being." Clinical experiences with babies suggest that the second stage, annihilation anxiety combined with bodily responses, is present in the latter half of the first year.

Some of my analytic patients have clearly described the overwhelming fears Winnicott lists during their recurrent states of traumatic overwhelming. These take the form of awake episodes of terror and frantic motor discharge, sometimes accompanied by bodily distress of nausea, abdominal discomfort and an urgency to urinate or defecate, and sometimes ending in total bodily collapse in a fetal position with paralysis of all functions. In the most severely affected patients any excess of stimuli, e.g., a minor change in their environment, can trigger such a recurrence of the traumatic state. They are sensitized to trauma in general. Their reparative measures include withdrawal, avoidance of all stimulation, and insistence on sameness; preoccupation with things as opposed to people—the latter being less predictable and controllable; a frantic separation anxiety, using the mother as a protective auxiliary ego. At a later point denial and passive into active may be used, for example, in the form of actively bringing on the traumatic state to
avoid being surprised by it and to "traumatize" the helpless onlookers. It also is a sign of the healing process when these patients' traumatic states begin to occur in response to specific stimuli or situations which in

**WARNING!** This text is printed for the personal use of the subscriber to PEP Web and is copyright to the Journal in which it originally appeared. It is illegal to copy, distribute or circulate it in any form whatsoever.

- 195 -

...some ways remind them of the original trauma, and it is further progress when the recurrences take place primarily or exclusively in the analysis and are linked to the transference. Some patients are at the stage of situation-specific traumatic recurrence when they start treatment, and it is not always clear whether they ever were generally sensitized to trauma or perhaps experienced only a brief period of that stage during the immediately posttraumatic time. The next milestone in the recuperative process is reached when, in the course of the analysis, and sometimes prior to it, these states of situation-specific annihilation anxiety become linked with and supplanted by later developmental anxieties and by contents which apply directly to the original trauma.

These clinical experiences have led me to regard the presence of annihilation anxiety in its various forms as another manifest indication that a trauma did occur, and to view the defenses against annihilation anxiety as well as its gradual change to other forms of anxiety, or even an admixture of other anxieties, as a measure of the ongoing reparative process.

Let me now turn to another aspect of trauma damage and the healing process which has seemed particularly important to me. In her study of adult analysands who were raped during childhood, A. Katan (1973) found that these patients were most severely affected in two areas, impairment of integration and drive defusion. These damages permeated their personality structures and functioning and could not be improved much through analytic treatment. My own work with children who could not feel good showed that these patients invariably also suffered from marked difficulties with drive fusion, integration and ability to develop and maintain neutral interests and to be creative in whatever form. All these characteristics proved to be psychically related to one another, and one of the genetic causes was the experience of trauma. In 1985, I attempted to trace the mutual dependence of these characteristics, discussed the factors which facilitate and impede their development, and suggested some clinical approaches to the problems they pose for the afflicted patients and their analytic work. In the context of the present focus on trauma, one finding is especially pertinent: Drive fusion can take place only when there is a sufficient quantity of libido in relation to aggression and when the libido is sufficiently bound to be securely under the sway of the pleasure principle. Binding the libidinal energy and indeed all stimuli is, in part if not wholly, accomplished through the function of integration. At the same time, integration depends on bound, as opposed to free-flowing, libido because it draws on this very source of energy to fuel its own functioning. Freud pointed out that the impact of trauma, the break through the ego's protective shield, and the flooding of the organism with excessive stimuli put the ego and the pleasure principle out of action. This means that drive fusion can no longer be maintained and that the integrative function which helps to bind excitations is totally or largely incapacitated. The damaging effect of trauma on drive fusion and integration is therefore particularly severe. The clinical manifestations of defusion and impaired integration are especially prominent in the personality functioning of traumatized children. This is most marked in those who experienced trauma during their earliest years because in them drive fusion and integration were interfered with during the initial, most vulnerable phases of development. As a result, drive fusion and integration fail to mature normally and cannot appropriately contribute to the progression of other areas of personality growth.

Yet it is just in these two most damaged areas of drive fusion and integration that we also can most readily follow the reparative process. It takes the form of gradually integrating the traumatic noxious excess of stimuli by libidinizing them—bringing them under the domain of the pleasure principle—and, at the same time, accomplishing the first steps in drive fusion. This shows itself in increasing sexualization of the traumatic event, alteration in some of its features, and linking with other more adequately mastered life experiences. In this form the trauma may be incorporated in anxiety dreams and nightmares with an element of wish fulfillment (succeeding the mere repetition compulsion of pavor nocturnus and stage IV nightmares with motor discharges); it often becomes the content of masturbation fantasies; it infiltrates behavior patterns and actively provokes interactions with others which partly serve instinctual gratification; it affects the formation of the superego and instincualizes its interaction with the ego; it may even libidinize the posttraumatic

**WARNING!** This text is printed for the personal use of the subscriber to PEP Web and is copyright to the Journal in which it originally appeared. It is illegal to copy, distribute or circulate it in any form whatsoever.

- 196 -

forms of anxiety. The primitive degree of fusion attained through this aspect of the reparative process is usually of a crudely sadomasochistic nature. This may be clinically distressing for the patient, his loved ones, and the analyst, and may indeed lead to secondary pathology, yet it represents definite strides in assimilating the trauma and in restoring maturational progression of drive fusion and integration.

**TRAUMA IN PARENTALLY BEREAVED CHILDREN**
Since the publication of *A Child's Parent Dies* (E. Furman, 1974), the original number of 23 parentally bereaved children treated by my Cleveland colleagues and myself has more than doubled. In assessing which of these patients were traumatized by their experience of the parent's death or by factors related to it, I have used the criteria listed above which indicate traumatic or posttraumatic responses. With some patients the data were gained during analyses that took place after the loss; with others, whose parent died during their treatment, the data include the actual time of bereavement. Many patients did not experience the death of the parent as a trauma. A number did. From among these I shall briefly describe four, to illustrate some of the earlier points and to raise further questions.

Miriam was the eagerly welcomed, healthy first child of a happy young couple. By 3½ weeks of age she thrived, seemed comfortable and well-contained, and had just begun to extend her sleeping periods at night. When Miriam was 4 weeks, her mother fell ill and died of a viral infection within 24 hours. The maternal grandmother immediately took over Miriam's full-time care and soon invested the infant as her own. I began to work with the grandmother a couple of months later. By that time Miriam was at peace and thriving again, but the grandmother described Miriam's immediate response to the upheaval. The baby screamed and fretted almost incessantly, refused food, suffered interference in all bodily functions, and could not be comforted. This state lasted for many days and only gradually diminished. One suspects she experienced a state of vegetative excitation or possibly an interruption in the "going-on-being," caused by the loss of what Winnicott calls the "holding environment" and what A. Freud terms the auxiliary ego provided by the mothering person. I worked with the grandmother for several years. She was unusually empathic with infants. This seemed to have mitigated even her own initial severe distress so that the child's traumatic response was all the more noteworthy. During her early years Miriam then weathered a number of stresses, and during her fourth year she experienced a near-total loss of her grandmother when the father's new wife insisted on taking her over and placed her in a daycare center. Miriam was deeply distressed but at no point showed a traumatic reaction. The development of drive fusion and ego functions was neither delayed nor impaired.

Danny (Fiedler, 1974), the third child in his family, was 11 months old when he and his father were hospitalized with a virus infection. The father died of it within 48 hours. The mother, distraught and preoccupied with her other more mildly ill children at home, could not visit Danny during his week-long hospital stay during which he underwent many medical procedures. When she came to take him home, he was pale, listless, and did not respond. He no longer walked or crawled, had lost his early speech and frettet almost incessantly, refused food, suffered interference in all bodily functions, and could not be comforted. This state lasted for nearly 2 years. Testing showed him to be of at least normal intelligence, but his persistent lack of affect and response made him appear mentally retarded.

The therapist's ongoing weekly interviews with the mother continued when Danny entered the Hanna Perkins School at nearly 3 years. His previously constant separation terror had subsided by this time but still reached panic proportions when he thought mother would leave him suddenly; for example, when he momentarily lost sight of her in a store, he screamed in terror to the point of turning blue and lost consciousness. His analysis, begun at age 4, showed that he remembered and missed his father and that his death troubled him in many ways. The real trauma, however, was the temporary loss of the mother at 11 months and some of the medical procedures he endured during her absence at that time; for example, when he was to be photographed, the idea that someone would take his picture reminded him of his X-rays during the early hospitalization and resulted in an episode of terror for him. Although these recurrences of terror states surfaced in barely mitigated form for many years, they were in time supplanted by heightened developmental fears, especially castration anxiety and early superego anxiety. He also began to use passive-into-active repetitions, instinctualized some aspects of the trauma, and linked it with other experiences. This showed itself in his running away, refusal to care for himself, magical denial of masturbatory dangers, and insistence that his mother could cure everything because she was a nurse. Danny's difficulty with drive fusion contributed to particularly harsh, early superego forerunners.

Ruth was 3½ years old when her father was murdered. She learned of this from her mother's frantic, instinctualized account and behavior. The impact was intensified by the mother's chaotic response during the following year and her propensity to externalize her fears, anger, and excitement to everyone, including Ruth, overwhelming them with gruesome details and unrealistic speculations. After a lovingly invested infancy, the child had already suffered repeated overwhelming through sexual and aggressive abuse and, during the months preceding the father's death, she had helplessly witnessed the parents' violent arguments and fights. During the period immediately following the father's death, Ruth seemed to have suffered very frequent states of total overwhelming, suggesting posttraumatic recurrences. These were sometimes ignored and sometimes punished as naughty temper tantrums. There also was evidence that, at least within the year, she overwhelmed others, turning passive into active. Her unfused aggression
manifested itself in physical sadistic attacks, especially on younger children, and in self-hurting masturbatory activities.

Ruth's analysis began in her sixth year during her attendance at the Hanna Perkins School. Highly intelligent and verbal, she was plagued by symptoms in all areas of functioning, many fears, extreme ambivalence, and inability to tolerate any increase in stimuli, for example, a change in routine or someone talking to her unexpectedly. Although it was difficult to disentangle to what extent Ruth's earlier experiences affected her response to her father's death and to what extent her integration of its trauma linked them together, some posttraumatic symptoms were understood to relate primarily to the murder: pavor nocturnus, a horror of everything related to violence and death, and recurring episodes of overwhelming fear of annihilation, accompanied by frantic motor discharges and bodily collapse into a fetal position, and by sensations of pain and an expectation of being killed. During the years of analytic work, her pavor nocturnus changed to repetitive nightmares and, later, specific phobic fears at bedtime. Her episodes of trauma recurrence became less frequent and more situation-specific and were mostly limited to transference reactions in the sessions. She also gradually achieved better control of the episodes—first by bringing on the overwhelming when she sensed it coming over her, then by experiencing it mentally without bodily sensations, and still later by being able to withdraw into a closet and calm down when it had barely started. By age 9, almost 6 years after the trauma and 3 years of analysis, Ruth showed evidence of signal anxiety. She could feel the threat of "it's coming" but could prevent feeling or manifesting terror. She coped at those times by asking to be left alone and playing quietly for a while. The contents of the trauma also became integrated in the form of passive-into-active provocations, sadomasochistic masturbation fantasies, and instinctualized aspects of superego, representing murderer and victim internally. Although drive fusion and synthesis were seriously impaired, Ruth could be helped to address and cope with all aspects of mourning the loss of her father through death. Its form, the murder, was the real trauma and has been much harder for her to master.

Jim (Schiff, 1974) was 7¼ years old when he experienced a car accident while driving with his mother, twin, a younger brother, and another mother and her four children. The car hit a bridge abutment and both mothers, Jim's twin, and three of the other family's children were killed. Jim sustained serious head injuries and only recovered consciousness after several weeks. For 3 months he was cared for in a hospital room he shared with his brother who was casted for limb fractures. He learned of the deaths there but did not acknowledge them, although his later analysis revealed that he had clearly remembered the pretraumatic and traumatic events. Jim's initial confusion and hyperactivity were probably organic but persisted after neurological impairment was ruled out. In addition, while he had been pathologically aggressive, he became quite passive and defenseless in his interactions with others and suffered frequent spells of sitting motionless, staring and losing touch with the world so that he failed to respond to what was going on around him, even to his family's efforts "to get him out of it." These symptoms were unchanged when he started analysis at age 10, almost 3 years later, and could then be understood and resolved.

Jim had experienced overwhelming terror and subsequently heightened anxiety at all levels. Castration fear contributed to his passivity and hyperactivity. His episodes of apathetic withdrawal ultimately warded off overwhelming sadness. In part these manifestations were posttraumatic, related to the nature of the deaths and injuries as well as to the loss of the mother and unavailability of emotional support and adequate care during the succeeding period. Jim's analysis revealed, however, that, at least by that time, his symptoms also had become linked with earlier separations during which Jim had been aggressively abused and neglected. These earlier experiences had heightened his developmental anxieties prior to the trauma and shaped his early defenses, serving especially to ward off extremely helpless feelings of unsafety, sadness, and longing.

**DISCUSSION**

These vignettes raise rather than answer many questions. The very selection of the cases and the sequence in which they were arranged imply that I wish to draw attention to the significance of developmental factors in our attempts to understand trauma. Following Freud and A. Freud in recognizing that the causes of trauma, at any age, depend on the unique individual confluence of internal and external circumstances, we may yet take it for granted that the immature ego is more vulnerable to traumatization. Whereas under good enough conditions the auxiliary ego

of the mothering person compensates for the infant's and young child's ego weakness, his very reliance on maternal functioning also increases his vulnerability. He may be traumatized because the mother's auxiliary ego does not function effectively, or because it becomes totally unavailable, or even because the mother actually causes the overwhelming excess of stimulations instead of
little girl, she could not help Ruth to contain and integrate the experiences. In part this left Ruth to struggle on her own, in part it led her to identify with the mother's unhelpful ways of coping, for example, it intensified her use of sadomasochistic sexualization and her passive-into-active tendency to overwhelm others. Jim's mother was dead. Although the analyst, from the time of the trauma on, assisted the family in a consultative capacity, it took 3 years before they could provide a measure of physical and emotional parental care. This delayed the start of Jim's analysis and perhaps also contributed to the delay in his recuperative steps. He was still showing auxiliary ego cures the effects of trauma or that it is the only deciding factor. We know only too well that mothers cannot prevent all the same posttraumatic symptoms.

While wanting to underline how significant a role mothering plays, I am not suggesting that optimal availability of the mother's auxiliary ego cures the effects of trauma or that it is the only deciding factor. We know only too well that mothers cannot prevent all stresses in a child's life and that recuperation from trauma can be impeded by unavoidable further debilitating experiences and no doubt by factors within the child. However, as with bodily traumatic injury, the posttraumatic milieu and protective as well as facilitating nursing care contribute considerably to the recuperative process.

The younger the child, the more total the overwhelming, the less available the mother's auxiliary ego, and the more stressful the posttraumatic period, the slower are the steps in the reparative process. We note this in the general sensitivity to traumatization, the recurrent experiences of annihilation fear or terror/panic instead of progression toward signal anxiety, the damaging impact on all functions which are in the process of development, and especially on integration and drive fusion. The impairment in these latter two processes takes again seems to depend in part on the posttraumatic support and experiences. This division into earlier and later developmental phenomena is not clear-cut. There are overlaps and other significant factors, among them the child's internalization of the mother's ways of auxiliary ego functioning, as was evident in the case of Ruth and as I discussed in greater detail in another context (E. Furman, 1985).

The older traumatized child is more likely to be able to "wall off" the trauma in the form of pavor nocturnus, episodes of withdrawal, affect block, and related posttraumatic symptoms. To an extent this protects him from recurrences of traumatic anxiety and helps him to preserve a measure of adaptive functioning until his ego can begin to use defenses and libidinization to assimilate the traumatic event. But whether or how soon such reparative steps are taken again seems to depend in part on the posttraumatic support and experiences.

This division into earlier and later developmental phenomena is not clear-cut. There are overlaps and other significant factors, among them the child's internalization of the mother's ways of auxiliary ego functioning, as was evident in the case of Ruth and as I discussed in greater detail in another context (E. Furman, 1985).

There are also developmental phenomena which are even harder to understand. Traumatized children, especially the younger ones, invariably reexperience the trauma in the transference, with the analyst as the agent who inflicted the trauma. In fact, this is how we usually learn about traumas in child analysis. When I asked several colleagues, among them A. Katan (1973), about their experiences in analyzing adults who had suffered a trauma in childhood, they told me that the patients hardly ever bring the trauma into the transference in this form and that their transference reflects only some aspects or features of it. Does this mean that the transference in childhood operates more strictly under the repetition compulsion? Does it mean that there are different developmental levels in the transference?
Of course, developmental factors do not account for all the many variations of posttraumatic manifestations or of the rate and nature of reparative steps. Nor do I think that the differences can be attributed simply to variations in individual endowment. It seems more likely that other specific factors play a part, either before the trauma or afterward. For example, recurrences of traumatic anxiety are, in some patients, not a sign of difficulty in recuperation but may at certain times point to progress. They sometimes signify that the psychic system has reached a point of transition from pre-ego to ego mechanisms and can begin to admit the anxiety to consciousness as a way of starting to deal with the hitherto unbound traumatic stimuli. Also, some manifestations associated with traumatic injury may stem from different sources. For example, severe damage to integration and drive fusion may be caused by factors other than trauma (E. Furman, 1985).

We also know very little about recovery. A. Freud suggested that complete recovery is impossible, that a vulnerability remains, perhaps unrealized until the individual encounters certain life situations. Miriam's good progress during her early years does not guarantee invulnerability. We would have to follow her analytically throughout her life to gain reliable data. Most cases, followed at least long-term, show that the inner work on a trauma never ceases. Even when the patient achieves signal anxiety in relation to his or her traumatogenic events, the personality continues to expend a great deal of energy on using such signal anxiety to remain on the alert, to differentiate past from present, and to integrate the remnants of the original experience which surface at such times—a form of working through.

This brings us to the role of treatment. Since its historical beginnings, psychoanalysis has been helpful to patients who had suffered a trauma. The very process of tracing a person's earlier traumatic experience and making it available to his consciousness assists him with integrating it, as do many other aspects of the analytic work, not least the transference. However, there are limitations. An analysis can be helpful only within the given of the patient's own rate and stage of recuperation. When a patient's ego is not ready to assimilate the traumatic event, or when the analysis forces his pace of integration too much, the treatment itself is experienced as a repetition of the traumatic intrusion. This may impede a patient's ability to engage in the analytic work in the first place, or to persist with it when he feels threatened. It may also cause some patients to experience setbacks in the reparative process if they have not been able to protect themselves with sufficient defenses. The analyst's awareness of the patient's precarious integrative capacity and his empathic skill in working with the patient is therefore especially important in these cases, as is an understanding of the steps in the recuperative process and a recognition of the limits of analytic help at certain points.

With children the analyst has an added task, namely, to apprise the parents of the child's psychic state and to enlist and support their functioning as auxiliary egos in relation to the posttraumatic recuperative process—a role that exceeds their usual age-appropriate caring and educational function with the child. The younger the child, the more is it helpful, nay essential,

that the parents understand and undertake this role. It is an ongoing round-the-clock job and provides the milieu for the child's effective use of the analysis. With the analyst's support many parents can and do fulfill this need when they are helped to appreciate the reasons for it, just as parents often rally to nurse their child through a bad sickness in cooperation with a caring physician.

Obviously, we know far too little about trauma, but I find that parents, physicians, and professional caretakers know even less. They tend not to appreciate the difference between trauma and stress, between long-term, perhaps lifelong, damage and potentially masterable upset. For example, in my consultations with child life workers in pediatric hospitals I have frequently noted that staff and parents are tempted to regard suggestions about the need for a mother's availability or preparation for procedures as optional frills which, at best, reduce children's unhappiness and, at worst, interfere with "getting on with things." Since prevention is so much easier than cure, especially in regard to trauma, perhaps the child analyst should take part in clarifying these issues with parents and professionals, not only after the trauma when the child needs or is in treatment, but before. Not all but many traumas can be avoided.

**SUMMARY**

Trauma and attempts at mastering it are metapsychologically differentiated from stress, and clinical manifestations of successive stages in the posttraumatic psychic work are described. Some of these are familiar, others have not been previously recorded. Four case vignettes illustrate the analytic understanding of patients who experienced the parent's death or circumstances related to it as a trauma. All of them raise further questions about trauma and posttraumatic mastery.

**REFERENCES**

FURMAN, E. 1956 An ego disturbance in a young child Psychoanal. Study Child 11:312-335
FURMAN, E. 1984 When is the death of a parent traumatic Read to the Association for Child Psychoanalysis, London.
FURMAN, E. 1985 On fusion, integration, and feeling good Psychoanal. Study Child 40:81-110
GREENSON, R. R. 1949 The psychology of apathy Psychoanal. Q. 18:290-302
KATAN, A. 1973 Children who were raped Psychoanal. Study Child 28:208-224
SCHIFF, E. J. 1974 Jim In Furman 1974 pp. 88-95
WINNICOTT, D. W. 1960b Ego distortion in terms of true and false self In The Maturational Processes and the Facilitating Environment pp. 140-152
WINNICOTT, D. W. 1963a The development of the capacity for concern In The Maturational Processes and the Facilitating Environment pp. 73-82
WINNICOTT, D. W. 1963b Morals and education In The Maturational Processes and the Facilitating Environment pp. 93-105
WINNICOTT, D. W. 1963c Dependence in infant-care, in child-care, and in the psychoanalytic setting In The Maturational Processes and the Facilitating Environment pp. 249-260

WARNING! This text is printed for the personal use of the subscriber to PEP Web and is copyright to the Journal in which it originally appeared. It is illegal to copy, distribute or circulate it in any form whatsoever.

Article Citation [Who Cited This?]

Copyright © 2007, Psychoanalytic Electronic Publishing.

WARNING!
This text is printed for the personal use of the subscriber to PEP Web and is copyright to the Journal in which it originally appeared. It is illegal to copy, distribute or circulate it in any form whatsoever.