

PSYCHIC TRAUMA, ANNIHILATION ANXIETIES AND PSYCHODYNAMIC TREATMENT BY MARVIN HURVICH, PH.D.
FOR NEW ORLEANS APA PANEL “TRAUMA: OBVIOUS AND HIDDEN: POSSIBILITIES FOR TREATMENT

PSYCHIC TRAUMA MARKERS

Key indicators of psychic trauma were delineated by Freud in 1920: a feeling of helplessness associated with sudden onset; surprise; an impact that is overwhelming; and obligatory repetition in the service of mastery. The subsequent literature includes many definitions of psychic trauma. Ferenczi (1933) added betrayal of trust, underscoring the importance of relational issues. An overall framework includes the components of a traumatic event, a traumatic process, and a traumatic effect, accompanied by painful affect. (Rangell, 1967, p 79).

A broad definition of psychic trauma was provided by Greenacre (1967): any conditions which seem definitely unfavorable, noxious, or dramatically injurious to the developing young individual” (p. 128). A narrower definition is that psychic trauma is associated with devastating and shattering experiences that result in internal disruption as a result of putting ego functioning and ego mediation out of action (A. Freud 1967, p. 242;), and may interfere with or threaten the integrity of the sense of self. (Pao?) A distinction has been made between a traumatic neurosis and a traumatic event (Mahony, 1984). In the former, most of the psychopathology is seen to result from the subject’s inability to assimilate the traumatic experiences. In the latter, the major traumatic significance is based on the role of the traumatic

event in activating psychopathological tendencies (p. 53). The current author adds that there are transitional phases between un-assimilability and the activation of latent psychopathological trends in the wake of traumatic experience. Both the traumatic neuroses and the traumatic event tend to arouse annihilation anxieties. The presence of annihilation anxieties may thus be seen to constitute trauma markers.

Psychic traumas can have organizing influences on the mental sphere, and play a dramatic role in shaping the further development of the individual. “The residues of the past and the content of the future tend to be formulated, constructed, and reconstructed in terms of that [traumatic] experience” (Dowling, 1986, p. 212).

Annihilation-survival fantasies comprise key psychic contents of trauma. Annihilation anxieties involve concerns over survival, self -preservation, and safety. Two central areas of concern are for the integrity of the sense of self and the intactness of the ego functions. Annihilation anxieties are triggered by survival threat; are found early but can be engendered throughout the life cycle; constitute a basic danger; are residuals of psychic trauma; have specifiable sub-dimensions; may occur in presymbolic form or be associated with fantasies in conflict and compromise formation; may arise with or without anticipation; may be accompanied by controlled or uncontrolled anxiety; are motives for defense; and may be associated with particularly recalcitrant resistances (Hurvich, 2003).

Annihilation anxieties can be specified on the level of clinical description and on the level of clinical generalization (Waelder, 1962). Examples from the level, of clinical generalization have been described as (a) fears of being overwhelmed, being unable to cope, and of losing control; (b)

fears of merger, entrapment, or being devoured; (c) fears of disintegration of self or of identity, of emptiness, meaninglessness, or nothingness, or of humiliation-mortification; (d) fears of impingement, penetration, or mutilation; (e) fears of abandonment or need for support; and (f) apprehensions over survival, persecution, catastrophe (Hurvich, 2003).

Specific annihilation fantasies that are residuals of the traumatic experience often serve as components in the organizing function of psychic trauma for the given person, centering around individually configured meanings of being overwhelmed, unable to cope, invaded, merged, and imminently destroyed. Zetzel (1949/1970) observed that soldiers whose narcissistic defenses of invulnerability protected them from experiencing any fear prior to battle were the ones whose sense of safety in the world was compromised as a result of exposure to combat, which fragmented their specific fantasies of invulnerability.

Annihilation anxieties can be shown to play a significant role in all the major forms of severe psychopathology, conditions which are especially found to include traumatic events in the life history: panic, nightmares, phobias, borderline, narcissistic and psychotic conditions, dissociative states, perversions, and psychosomatic disorders (Hurvich, 2003a). Sharon Farber, a member of today's panel, has written convincingly about the relation between eating disorders and annihilation anxieties (Reference).

When annihilation fantasies are accompanied by markers characterizing the more pathological, maladaptive, and primitive pole (uncontrolled anxiety, disorganizing regression), the reaction is more likely to qualify as a traumatic response. Conversely, when the markers found along with annihilation content are on the more adaptive side (controlled anxiety, presence of

reflective awareness, etc.), there is a greater likelihood that it is an anticipation of a traumatic situation. Time for recovery, and traumatic residuals, including the possibility of a traumatic neurosis or Post-Traumatic Stress Disorder are relevant here. Time of onset, be it infantile, childhood, adolescence or adulthood, is a key variable. Severe childhood trauma tends to result in a permanent expectation of a return of the traumatic state and dread of its return. A fear of emotional experience develops and this results in an impairment of affect tolerance (Krystal, 1989). Under debate is the contribution of psychic trauma to pathogenesis more generally, and how to distinguish pathological influences of trauma from other pathological effects. While his conception of psychic trauma changed as his theories evolved, Freud (1939) attributed a key role to psychic trauma in all symptom formation.

The expansion of trauma theory, and a first step toward an integration with the psychoanalytic theory of anxiety, involves the formulation that the experience of being overwhelmed, a signature of the traumatic moment, can also be anticipated and associated with controlled anxiety, and hence be included in the basic danger series (Hurvich, 2001, 2003a). Thus, issues related to being overwhelmed or annihilated (Freud, 1923, p. 57) may be part of a traumatic moment in present time, or may constitute a danger situation that is anticipated in future time: concerns about being overwhelmed may thus be either present, actual, or potential threat (Schur, 1953; Hurvich, 2003a&b).

Traumatic events are experiences processed by the subject as constituting a threat to psychic and/or physical survival. A basic assumption is that shock and strain trauma decrease a sense of safety, increase a sense of vulnerability in the world, and a heightened fear of imminent

destruction--mortal terror. This threat is reflected in fantasies, conscious and/or unconscious, that have survival-annihilation content, and in defensive-restitutive fantasies and behaviors directed against the fantasies and the disruptive and sometimes intolerable affects associated with them. While the DSM-Kraepelinian approach emphasizes descriptive, observable, symptomatic manifestations of psychic trauma, the more recent PDM – Psychodynamic Diagnostic Manual, 2006—to be reported on this Saturday in a meeting to be chaired by Nancy McWilliams – additionally includes a focus on intrapsychic events and much more.

Annihilation-survival-related contents and anxieties involve terror, fright, and dread. They reflect residues of and intrapsychic reactions to traumatic experience. The ideational aspect entails a dynamic fantasy content that is found at varying levels of symbolization/mentalization, such as fears of being overwhelmed, unable to cope, merged, invaded, and losing or being negated in one's sense of self. Such fantasy contents, uniquely elaborated by each individual, and the defenses against them, extend and particularize the utility of the concept of psychic trauma. They are amenable to psychotherapeutic inquiry as are other psychic contents (Hurvich, 2003a). This schema has been used to construct measures to assess annihilation anxieties clinically (Hurvich, 1991, 2003a; Hurvich & Simha-Alpern,1997) and empirically (Hurvich, et.al., 1993; Levin & Hurvich, 1995; Benveniste et.al. 1998).

POSSIBILITIES FOR TREATMENT

Anna Freud (1936) pointed out that the general technical rule of analyzing the defenses did not have a favorable therapeutic result when the defense had been engendered as a result of the patient's fear of the strength of his drives. This technical caveat was a major basis for the clinical

application of ego psychological principles to the theory of technique with more disturbed individuals, who regularly manifest traumatic residues and annihilation anxieties. Analyzing the defensive aspect of these patients' material tends to interfere with ego functioning and the maintenance of a coherent sense of self. Since the self tends to be an organizer of ego functioning, any therapeutic interventions which strengthen the coherence of the self will aid in improving the level of adaptive behavior. These include reflective (empathic) responses, other forms of support, some encouragement, providing of transitional objects, verbal and nonverbal refueling, and, sometimes, a degree of self-disclosure. These, in addition to the standard clinical procedures of clarification, interpretation, and reconstruction, further self-integration.

There are always a number of considerations relevant to the therapist-patient setting. For those who manifest high levels of annihilation anxieties and a traumatic history, an important issue involves the therapist protecting, maintaining, and enhancing the patient's sense of safety and comfort in the room. With such patients, timing and tact trump most other concerns, especially until a trusting relationship and a working alliance have been established. This is both difficult, and not always realizable. Due to the substantial and sometimes extreme sensitivity of such individuals to narcissistic injury, hostile or critical overtones and seductive or rejecting implications in the therapist's tone and message are especially toxic and counter-therapeutic.

For patients prone to panic experience, a supportive, calm, containing, and non-intrusive stance by the therapist helps the patient increase his tolerance for anxiety. Judicious, relatively ego-syntonic interpretations facilitate the patient's integration of cognitive and affective components of his experience.

From the interpretive side, it is often helpful to analyze and work through maladaptive ego functioning. "We have to show the patient, not only the many determinants of his anxiety, but also how and why a given situation gets out of hand and deteriorates into a traumatic situation. [Schur, 1971, p. 117] A relevant goal here is to facilitate the shift from uncontrolled to controlled anxiety.

A detailed knowledge of the clinical manifestations and implications of the major manifestations of annihilation anxieties is helpful. Such relevant phenomena as fears of being overwhelmed, merged, invaded, disorganized, in addition to excessive concerns over death, dying, bodily harm, and serious injury are also manifestations of excessive annihilation concerns, and it is therapeutically useful to underscore the annihilation meaning of such fears and to elicit associations when the patient is capable of such activity.

Relevant to all of this is that annihilation concerns of the patient, when these are extensive and strong, often trigger related issues in the therapist. One of the challenges of helping these difficult patients is the successful utilization, processing, and control of countertransference reactions. Since obligatory repetition is a major feature of psychic trauma (Freud, 1920), an especially challenging aspect of working with these patients is their strong, typically unconscious tendency to do to you what was done to them, to induce you to do to them what was done to them, and other variations of the Law of Talion (Hurvich, 2006). Winnicott's sage advice, to avoid retaliating against the patient, is more likely to be achievable when the therapist is able to process her or his countertransference reactions. An additional complicating factor here is that the patient's traumatic repetitions are typically accompanied by annihilation and death-related imagery/fantasies.

But the problem of annihilation anxiety-related countertransference reactions in the therapist are found in a broader range of therapeutic work with disturbed patients. The persecutory/malevolent transference attitudes of psychotic and especially paranoid patients are frequently experienced by the therapist in the countertransference as threatening her or his psychic survival. As J. Wallerstein (1997) has written, "The central countertransference of the clinician, namely, the fear of annihilation, provides the key to the primitive psychological roots of the transference and illuminates the highly disturbed psychological functioning of the patient. For the clinician is not reacting with the kind of anxiety that is aroused in a relationship with a neurotic patient, but with a

much greater, far more primitive fear of personal and professional annihilation.”

There is a basis to conclude that underlying traumatic residues play a role in the background of many seriously disturbed patients who do not meet the criteria for traumatic neurosis or PTSD (Hurvich, Knafo 2004).

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