Following September 11th, mental health personnel in the New York City Metropolitan area were called upon by the Red Cross, the NYPD and many corporations to conduct group and individual stress management and emergency therapy sessions. Large numbers of New Yorkers, indirectly affected by the tragedy, sought emergency counseling at the Red Cross and at clinics, hospitals, and other facilities in the local area. The haunting images repeatedly shown on TV of people jumping from high floors and of others running for their lives from falling debris with smoke-dust filled clouds surrounding, them stirred annihilation apprehensions in many local people.

From therapy patients, supervisee reports, discussions with colleagues, and in numerous meetings sponsored by a host of organizations, there were indications of a widespread increase in anxiety levels, especially with regard to concerns over safety, survival, and self-preservation. These are the apprehensions that constitute annihilation anxieties, and that are central sequela of psychic trauma. The view that feelings of overwhelmed helplessness constitute the psychic content of trauma (Furst, 1967, p. 37) is here extended to the position that experiences of
overwhelmed helplessness tend to include the terror of imminent extinction, and that
annihilation-survival fantasies also form a key psychic content of trauma (Hurvich, 1996).
Repeatedly expressed annihilation apprehensions of trauma victims are of being destroyed,
overwhelmed, and unable to cope, of merger, intrusion, disorganization of the sense of self, loss
of needed support, and expectations of additional catastrophe. This chapter will focus on
delineating annihilation anxieties and thereby elaborating on frequently found fantasy mental
contents that are associated with psychic trauma.

Patients describe feelings of being overwhelmed by the external threat as well as by
helplessness, vulnerability, and anger. They depict anticipations and fantasies of being buried
alive, smothered by debris, trapped in a burning building, choked to death by poison gas, and
blown apart by the next imminently anticipated attack. A substantial number of school children
were reported in the New York Times to have experienced high levels of fear and stress months
after the event.

Another phenomenon was the re-awakening of early traumas. It has long been recognized
that a current trauma tends to serve as a trigger for traumatic events from one’s past becoming re-
activated. In many cases this re-arousal of old traumatic experiences is accompanied by the
activation of annihilation anxieties. One male executive in his early forties I saw for a
consultation two days after the twin tower collapse reported having left Tower Two soon after
the first suicide plane hit. While his office was on a high floor, he had luckily been on a lower
floor at the time, and was able to escape to safety. Many of his co-workers were killed. While
grieved and shaken, he reported that since his escape, he had become most preoccupied with an
event that had occurred ten years earlier that had not been in his awareness for some time. This
related to an accident where a friend had been killed, and where he felt some responsibility for
encouraging the friend to engage with him in a somewhat risky recreational activity, in spite of
the friend’s reluctance. The patient reported feeling overwhelmed with guilt and anxiety, and a
heightened fear of catastrophe.

As war hysteria has grown, and Homeland Security alerts have been widely broadcast, the
World Trade Center destruction is serving as a background trauma which gives a terrifying
reality to the possibility and high likelihood of the next strike, either from El Qaieda, Iraq, or
others. These current events are supplying the imagery for latent annihilation fears. New Yorkers
are experiencing and expressing much more annihilation anxiety in anticipation of a dreaded
assault which could come from anywhere at any time. The atmosphere is entirely different from
the days prior to the 1991 Gulf War, when direct retaliation seemed remote, and before the
traumatic experience of September 11th, which left a feeling of anticipatory destruction and
doom.

These recently triggered widespread terror experiences have much in common with
responses to war, plague, flood, and famine throughout the ages (Sorokin, 1942/1968). A number
of chapters in this book delineate aspects of group terror situations. This chapter will be focused
on terror experience as a component of psychic trauma in psychopathology. The hypothesis will
be developed that a marker and residue of psychic trauma is annihilation anxiety.

**PSYCHIC TRAUMA MARKERS**

Key indicators of psychic trauma were delineated by Freud in 1920 as a feeling of
helplessness associated with sudden onset, surprise, an impact that is overwhelming, and
obligatory repetition in the service of mastery. In the subsequent literature, many definitions of psychic trauma have been formulated. Ferenczi (1933) added betrayal of trust, which underscores 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 and unpleasurable 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). Anna Freud (1967) includes as required trauma criteria, action paralysis, numbness of feeling, temper tantrums in a child, and “physical responses via the vegetative nervous system taking the place of psychical reactions” (p. 242). These indicate ego function disruption, and that the person is operating with pre-ego modes. A distinction has been made between a traumatic neurosis and a traumatic event (Mahoney, 1984). In the former, most of the psychopathology has been seen to result from the subject’s inability to assimilate the traumatic experiences. In the latter, the major traumatic significance is seen to be 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.

Dowling (1986) emphasizes the psychological meaning of the traumatic experience, and
that this will be influenced by the person’s “developmental level, prior individual experience, and
instinctual, ego and superego configurations” (p. 209). The question can be raised whether
accenting meaning, and the other important variables Dowling specifies requires sidelining the
criteria set forth by Anna Freud, Krystal and others.

Dowling demonstrates the importance of meaning when he writes that psychic traumas
can have organizing influences on the mental sphere. “An organizing event is one which provides
a nexus around which a variety of previously existing and later developmental and conflictual
issues aggregate and achieve a more powerful, cohesive, and determinative meaning. An
organizing event or experience has 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 experience” (p. 212).

As mentioned before, annihilation-survival fantasies comprise a key psychic content of
trauma. Annihilation anxieties involve concerns over survival, self-preservation, and safety.
Sandler (1960) pointed out that a threat to the intactness of the ego includes a lowering of
feelings of safety, and the experiencing of anxiety following the danger of being traumatically
overwhelmed. The two key areas of concern are for the integrity of the sense of self and the
intactness of the ego functions.

Specific annihilation fantasies that are residuals of the traumatic experience often serve as
organizing events 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.

Another concept consistent with the annihilation component of psychic trauma is what Lifton called the “death imprint:” “..[A] radical intrusion of an image-feeling of threat or end to life” (1979/83, p. 169). He elaborates: “The degree of anxiety associated with the death imprint has to do with the impossibility of assimilating the death imprint--because of its suddenness, its extreme or protracted nature, or its association with the terror of premature, unacceptable dying. Also of considerable importance is one’s vulnerability to death imagery—not only to direct life threat but also to separation, stasis, and disintegration—on the basis of prior conflictual experience” (p. 169).

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). Karon & Vandenboss, (1981) wrote “The schizophrenic patient lives in a chronic terror state, which is so strong that other affects do not appear.” Teixeira (1984) references reports in the literature of schizophrenic patients’ fears of dying or being killed. He further points out that an overwhelming conscious fear of death in some schizophrenics immediately precedes the psychotic decompensation. “This extreme primitive death anxiety has been referred to as “annihilation anxiety” (p. 377).

Buie & Adler (1973) described annihilation anxieties in borderline pathology, while Kohut’s 1977) theory, which emphasizes disintegration anxiety, has been characterized as

Annihilation-survival anxieties are underscored by child analysts in many important papers on severe childhood disturbance, published in The Psychoanalytic Study of the Child. The case histories of these children are rife with examples of psychic trauma. Thus, annihilation anxieties are seen to be prominent in forms of psychopathology in which there is frequent evidence for psychic trauma.

While the narrow conception of psychic trauma has the advantage of clarity and specificity, the broader view, in the absence of clear evidence of shock, includes many phenomena widely understood as traumatic. There is clinical evidence that strain and cumulative traumas can influence personality development in ways similar to shock traumas, sans verified shock. In line with the goal of forging links between the psychoanalytic theories of psychic trauma and of anxiety, the following model (Hurvich, 2003a) specifies some variables that terror and anticipatory danger have in common.

**The Relation Between Traumatic and Signal Anxieties**

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<th>TRAUMATIC ANXIETY</th>
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When annihilation fantasies are accompanied by markers characterizing the more pathological, maladaptive, and primitive pole, 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. The important issues of time for recovery and 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 results in a permanent expectation of a return of the traumatic state and dread of its return. The fear of emotions develops and thus, 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, 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).

It is relevant to note the widely disseminated behavioral and symptomatic shock trauma markers, in addition to feelings of helplessness. Major ones are hyper-arousal, constriction, dissociation, and denial. Additional symptoms are intrusive imagery or flashbacks, sensitivity to light and sound, hyperactivity, abrupt mood swings, reduced ability to deal with stress, and difficulty sleeping. Next come symptoms like panic attacks and phobias, exaggerated startle, avoidant behavior, frequent crying, amnesia and forgetfulness, inability to love, nurture or bond with others. A set of symptoms that takes longer to develop involves problems with commitments, chronic fatigue, psychosomatic symptoms, and diminished interest in life. (Levine, 1997 pp. 147-149) In the latter group, Levine mentions fear of dying, going crazy, or having a shortened life (p. 149).

The DSM IV authors include behavioral symptoms like these just mentioned, and specify that the traumatic event is one that threatens death, serious injury, or physical integrity of self or
others. The central assumption of this chapter is both consistent with and an expansion of the key threat delineated in the DSM IV for Posttraumatic Stress Disorder. 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 psychodynamic approach additionally includes a focus on intrapsychic events.

These 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).

**CHARACTERISTICS OF ANNIHILATION ANXIETIES**
The following propositions give the reader an overview of the characteristics of annihilation anxieties as understood by this author. For a more detailed discussion, see Hurvich (2003c).

1). The danger associated with annihilation anxieties is survival threat.

2). Annihilation concerns are early dangers, but can be engendered later and throughout the life cycle whenever there is a perception-fantasy of survival threat.

3). Annihilation anxieties constitute a basic danger, and interlink variously with the four widely accepted basic dangers.

4). Annihilation anxieties are centrally involved in the experience of psychic trauma, and comprise major traumatic residuals.

5). Excessive annihilation anxieties, especially during the developmental years, increase the likelihood of ego function weakness and self pathology. Conversely, ego weakness and self pathology increase the likelihood of excessive annihilation anxieties.

6). Annihilation concerns may be encoded in a concrete somatosensory, affective, presymbolic form.

7). Annihilation apprehensions, as with the four typical dangers, may be identifiable as dynamic psychic content, and constitute a component in a conflict-compromise matrix.

8). Annihilation anxieties may occur with or without anticipation.

9). Annihilation-related themes/fantasies, may be accompanied by uncontrolled or controlled anxiety.

10). Annihilation fantasies and affects constitute motives for defense.

11). Fears of being overwhelmed are importantly related to aggressive as well as to libidinal
impulses associated with self and object representations.

12). Annihilation anxieties are found in psychotics and in non-psychotics.

13). Anxiety and symptoms may be experienced as psychic danger, and can trigger annihilation anxieties as secondary phenomena.

14). Symptoms, beliefs, affect states and behaviors are especially resistant to change when they are defending against annihilation anxieties.

**DIMENSIONS OF ANNIHILATION ANXIETIES**

Annihilation anxieties can be grouped into sub dimensions. They are: a) Fears of being overwhelmed/of being unable to cope/ and of losing control; b) Fears of merger/being devoured/ or entrapped; c) Fears of disintegration of self and of identity/of emptiness, meaninglessness and of nothingness/ fears of humiliation-mortification; d) Fears of impingement/ penetration/ mutilation; e) Fears of abandonment/need for support/ and, f) Apprehensions over survival/ persecution/ catastrophe.

1). **Fears of being overwhelmed** /of being unable to cope / and of losing control ; fears of overstimulation , of regression including loss of control of aggressive or sexual urges, of bowel and bladder functions, of bodily equilibrium as in vertigo, loss of control of the mind, including of going insane . Ritvo (1981) described how sexual excitement may be associated with fantasies of "falling apart, exploding, rupture of the skin, and running out of body contents" (p.348).

The following statement of a patient in psychoanalysis demonstrates how current concerns can trigger earlier traumatic fears of being overwhelmed:

"These big worries I am having now remind me of the tonsillectomy [age 3-3\4]. It is
closing in around me, suffocating me. Being restrained, held down, unable to move. This light coming toward me, I can't get away from it. It's so much more powerful than me, it's going to crush me... The ether—a sense of powerlessness, fears of death and of abandonment. It's got its grip on me and I feel myself dying. It is snuffing out my life. My body feels like it is deteriorating. I need some trick or sleight of hand to slide out and get away from it." This essentially neurotic patient, in the course of a full psychoanalytic treatment, repeatedly returns to associations of the tonsillectomy in the wake of current dangers. And as we have worked through some of the related conflictual aspects of this traumatically infused intrapsychic conflict situation, derivative fears (of cancer, heart attack, AIDS), have diminished. Steiner (1990, p. 113) reports a similar finding of fear of dying from the anesthesia mask, where the patient's career choice was related to the wish to save his own life and that of the object.

Krystal (1988) concluded, on the basis of long experience with victims of massive trauma that while all manner of symptoms and diagnoses were found, the common psychopathological manifestation among these individuals was the presence of overwhelming affects, especially a mixture of depression and anxiety (p.142).

Being overwhelmed involves an inability to establish a coherent response, and can lead to disruption, disorganization, and loss of control. Some cognates are: being flooded, buried, submerged, drowned, deluged, engulfed, crushed, immobilized, and overpowered.

One patient described the effect of anxiety on his ability to cope as follows: "I can't stand fear; I need comfort. Once fear steps in, I can't see anything or do anything. There are so many things I do out of fear. I'm afraid I'll fall apart, lose control, be taken over, be shot down with a machine gun.... The fear was always of something extreme happening. I won't get smacked; I'll get bombed. Some people fight or run away. When I'm cornered, I crumble."
And another patient, with a history of early childhood trauma stated, when faced with current issues that were triggering earlier traumatic memories: "My mind is being deluged with all sorts of frightening thoughts and images. My body is all nerves. I can't sit down for any period of time; I'm constantly up and down. I feel I'm going to crack up. At my job I can't do a thing; I just feel I can't go on". As with the other patients mentioned here, this one frequently voiced such fears, and they were accompanied by a decrease in the ability to cope with environmental requirements and challenges.

2). **Fears of merger.** These include fears of being devoured or entrapped; fears of smothering, choking, drowning, and of being buried alive; fears of being absorbed and engulfed. Related terms are fusion, engulfment, and re-engulfment. The fear of merger ("re-engulfment") is described by Mahler as an age appropriate attribute of the toddler.

What are the considerations associated with merger fears as a source of annihilation anxieties? The psychic danger is the threat of loss of the separate sense of self. Anna Freud (1952) portrayed how threats to ego intactness (a regular feature of traumatic experience), can result from psychic merger with the love object, and lead to loss of personal characteristics. Such merger wishes are one defensive effort that may follow traumatic experience.

3). **Fears of disintegration of self and of self identity.** These are major concerns for traumatized individuals. They include apprehensions of falling apart, or crumbling; apprehensions over disappearing, leaking out, evaporating, melting away, of emptiness and of nothingness, and fears of humiliation-mortification. Disintegration involves a decrease in the level of mental organization, a decrease in structural integrity. Decreases in mental structure tend to trigger anxiety as an alarm reaction, under conditions in which they constitute a danger to the organism's capacity to cope. Arlow (1989) wrote about a borderline patient: "What disrupted the patient's
psychic integrity was her fear that she might not be able to control her murderous rage toward Dr. Z and toward her mother" (p. 524).

As already mentioned, psychotic individuals have much traumatic experience in their backgrounds. Frosch (1967) holds that considerable psychotic symptomatology is understandable as a fear of psychic death through dissolution of self and object, or as an attempt to preserve contact with reality and object in the interest of psychic survival. He depicted the presence of fragmentation prior to the formation of part-self and part-object images and as a forerunner of splitting, and that splitting in the borderline patient is a counterpart of fragmentation in the psychotic.

4). Fears of impingement/penetration. Impingement fear is widely described as a post-traumatic phenomenon. Key related terms are being invaded, penetrated, intruded upon, imposed upon, encroached upon, and violated. There is a significant developmental basis for this vulnerability. Winnicott (1962) held that annihilation anxiety develops in the early postnatal period, but only in response to environmental failure and as a result of excessive reaction to impingement. An excess of such reacting produces not frustration but a threat of annihilation. "Impingement is an intrusion on the infant at times when he is not reaching out, and the result is that he withdraws from an unwanted impact...[This] "disturbs the continuity of the going on being of the new individual." (1958, p.245). The essence of bad mothering has been seen as impingement on the infant, as a result of the mother's failure in active adaptation to the infant's needs. The likelihood is increased for premature but overly brittle ego development (Khan, 1963) and an overdeveloped false self (Winnicott, 1960). While the centrality of developmental considerations in massive psychic trauma is under debate (Rothstein, 1987), those individuals who suffered excessive impingement during their early years are more vulnerable to intrusion experiences in psychic
trauma. According to Bick (1968), a sense of being overly vulnerable to penetration by others is increased when there have been inadequate experiences of "adhesive identification" due to unsatisfactory or inadequate skin contact with the mother during earliest infancy. It leads to fantasies of the self as porous and unable to hold or contain anything.

One patient described her feelings about being impinged upon this way: “I feel someone could easily violate me, mentally, physically and emotionally. And I would be shattered to pieces. Everything inside me would become like shattered glass, and couldn't come back together.” This patient suffered repeated abandonment trauma with the mother, and chronic, terrifying beatings and threats from the father.

Another patient who suffered from multiple childhood psychic trauma, and importantly from an intrusive-punishing, blaming father, would speak more rapidly and loudly in the therapy session if he anticipated that I was about to talk, and he would perceive any reaction from me as an intolerable interference. These experienced intrusions triggered fears of annihilation. He could not bear to have any activity interrupted, felt that what he was doing would be completely ruined, and that interrupting and spoiling were threatening to drive him crazy. Reading an article or a chapter in a book without interruption calmed him and decreased his fear of going insane.

5). Fears of abandonment/need for support/falling forever/falling into a “black hole”. These issues, like the others here specified, have traumatic effects in development. For many youngsters, excessive abandonment fears result in increased vulnerability to subsequent psychic trauma, and also increase following psychic trauma. Needed support includes all the requirements for caretaking and dependency characteristic of the pre-object-constancy child, who is struggling with issues relevant to merger fantasies and separation-individuation issues (Mahler, Pine & Bergmann, 1985). Childhood experiences of helplessness and of being
overwhelmed are universal. It is in a person who has not yet adequately developed techniques for self regulation, self care, and emotional self-reliance that loss of support tends to trigger annihilation anxieties. The anxiety over loss of needed support is found in persons who are overly dependent, and who respond with panic and dread to the threatened loss of a significant person, or when they are faced with increased responsibility, which often has the meaning to the person that he/she will lose dependent support. This is one group of individuals who have an increased vulnerability to the pathological aftermath of psychic trauma.

Winnicott's (1958) holding environment concept centers on the availability of needed support for the infant. It includes timely and reliable availability, attunement to factors associated with disequilibrium in the subject, and protecting the infant from overstimulation and impingement. He wrote that either being or annihilation are the only options for an infant during the holding phase. Winnicott (1952) proposed three main kinds of anxiety which result from problems in early maternal failure: unintegration, leading to a sense of disintegration; breakdown of the relationship between psyche and soma, which leads to depersonalization; and the feeling that one's center of consciousness has moved from the core to the shell. These feelings of anxiety, which are the earliest and occur normally in the context of maternal failure, are heightened to an unmanageable degree when environmental failures occur too rapidly and too often. There is, then, a predisposition to return to a primary unintegrated state under regression. The baby, in its earliest stage lives always "on the brink of unthinkable anxiety" (Winnicott, 1962, p.57). Where there is a weak ego organization, this experience of anxiety is persistent. Unthinkable anxiety manifests itself in later life in fears of falling to pieces, falling forever, having no orientation, or a fear of no sense of relationship between mind and body (Winnicott, 1958).
So one manifestation of the fear of loss of needed support is the fear of falling. This may be found in an adult in various forms. Paulina Kernberg (1980) sees fears of darkness, silence, solitude, loneliness, and emptiness as sometimes connected with the fear of falling. Failures in the early holding function of the mothering environment are suggested when these fears are persistently found. Kernberg pointed out that the relatively high rate of suicidal attempts in 6 to 12 years olds she observed in a psychiatric hospital frequently involved jumping out of a window. This may have the meaning of "actualizing the child's hopelessness, namely, that he is indeed falling out of maternal supports and into the arms of a black void--the absent mother" (p. 608).

6). **Apprehensions over survival/persecution** and of **catastrophe**. Being killed, destroyed, fears of world destruction; of fire and brimstone, the apocalypse, the twilight of the gods, doomsday, the death imprint. This involves a tendency to respond with a life-and-death attitude to danger, perceived threat or other situations which usually arouse some fear or anxiety. Krystal (1988) describes a "doomsday orientation" which involves a deeply pessimistic attitude, with concurrent persistent fears and a depressive lifestyle in persons who suffered early psychic traumatization. A catastrophic mentality is one of the most frequent responses to psychic trauma. In those who have suffered massive psychic trauma, it has been characterized as a "doomsday orientation," "a dread expectation, even conviction, that lightening always strikes twice, and that sooner or later, the fate worse than death will return" (Krystal, 1988).

One patient stated: "I feel I will explode because I can't contain the turmoil. I fear that at any moment my life will become a catastrophe. When the catastrophe happens, I will become emotionally unhinged, and it will destroy me because I can't overcome it. When I tell myself all the rational things to calm my fears, it does not help. It makes it worse because I feel I'm going
insane, since I think one way and feel another.”
SUMMARY

As a result of the terrorist attack on the World Trade Center, New Yorkers are experiencing and expressing increased apprehensions over another unpredictable, dreaded assault. There are heightened concerns over safety, survival, and self-preservation. These are the apprehensions that constitute annihilation anxieties, and they are central sequelae of psychic trauma. Experiences of overwhelmed helplessness tend to include the terror of imminent extinction, and annihilation-survival fantasies constitute a key psychic content of trauma. Expressed annihilation apprehensions of trauma victims are of being destroyed, overwhelmed, and unable to cope, of merger, intrusion, disorganization of the sense of self, loss of needed support, and expectations of additional catastrophe. This chapter contains a description of annihilation anxieties and thereby underscores frequently found fantasy mental contents that are associated with psychic trauma. The position was developed that terror experience is a component of psychic trauma in psychopathology, and that annihilation anxiety is a marker and residue of psychic trauma.

As clinicians, a thorough understanding of annihilation anxiety and its sequelae will allow us to better enable our clients to understand and cope with psychic trauma and the associated threat of annihilation.
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