INTRODUCTION

The goal of this paper is to delineate the concept of annihilation/traumatic anxiety and to situate it in relation to psychoanalytic theories of anxiety and of psychic trauma. In addition to its Dimensions, a further goal is to demonstrate the central relevance of annihilation anxieties for the more disturbed range of psychopathology. First, the issue of anxiety more generally.

Anxiety as a Key Issue in Psychopathology

Freud’s struggle to understand the problem of anxiety took him in various directions. In his first major writing on the topic, he separated anxiety from neurasthenia and identified the symptoms of anxiety neurosis (Freud, 1895). By 1917, he proposed anxiety to be a key issue in psychopathology: "We thus find ourselves convinced that the problem of anxiety occupies a place in the question of the psychology of the neuroses which may rightly be described as central" (p. 411). Also in 1917, Freud brought anxiety into the same framework as fear, while distinguishing them: fear as proportional concern over realistic threats; and anxiety as often exaggerated apprehensions regarding fantasied menace.
In his 1926 reformulation, Freud (1926) spelled out how anxiety becomes a stimulus for defense, adaptation, and symptom formation: “...symptoms are created so as to avoid a danger situation whose presence has been signaled by the generation of anxiety” (p. 129). While his 1895 anxiety theory was based on considerations of psychic energy, by 1926 the focus centered on meaning and included the ego functions of anticipation, recognition, and memory (Schafer, 1983).

For Freud (1926), the riddle of anxiety was part and parcel of the riddle of neurosis: “...a great many people remain infantile in their behavior in regard to danger and do not overcome determinants of anxiety which have grown out of date. To deny this would be to deny the existence of neurosis, for it is precisely such people whom we call neurotics” (p. 148).

That anxiety has remained of pivotal importance in psychoanalytic theory and practice is reflected in Compton's (1972) statement in his three part comprehensive review of the concept: "...almost every psychoanalytic investigation touches in one way or another on the problem of anxiety" (p. 341).

Anxiety also played an important role in the writings of Melanie Klein, and she related it closely to aggression: “From the beginning of my psychoanalytic work, my interest was focused on anxiety and its causation” (Klein, 1948, p. 41), and her emphasis was on very early manifestations. In 1932 she had written that the fear of annihilation is the origin of anxiety and that its ultimate source is the destructive instincts. She described persecutory anxiety as universally typical of the paranoid-schizoid position, and that it involves a
fear of engulfment and annihilation from an uncontrollable, overpowering object that may be experienced as internal or external. The pain resulting from insufficient gratification is hypothesized to be experienced by the infant as an annihilation-threatening persecutory assault (Klein, 1958/1975). We note here that in persecutory anxiety Klein is extending anxiety theory beyond a one-person phenomenon.

In spite of the considerable importance Klein attributed to annihilation anxieties, she included little direct discussion of psychic trauma. Acknowledging this, Britton (2013) wrote: “I believe that this absence is because the concept of psychic trauma has been incorporated into the theory of general psychic development that Melanie Klein produced and Bion extended. Pathological (traumatic) versions of the paranoid-schizoid and depressive positions are described; the early Oedipus situation and its vicissitudes; and the consequences of failure of “containment” that may result, as Bion put it, in psychological catastrophe” (p. 86).

Winnicott (1962) did utilize the term trauma though his major contribution in the anxiety/trauma literature was his concept of primitive agonies, psychotic anxieties and the disruptions from impingement, which have central traumatic implications.

**Psychic Trauma & Psychoanalysis**

The inter-relationship between psychic trauma and annihilation anxieties is underscored by the fact that traumatic events are defined as experiences processed by the subject as constituting a threat to psychic and/or physical
survival. It is a truism to acknowledge that psychic trauma is a significant topic on the mental health scene today. Its diversity is challenging.

In addition to traumatic neuroses, there are many varieties of psychic trauma, such as shock trauma and strain trauma, the latter also called cumulative trauma (Khan, 1963). There are single event traumas and repetitive traumas as well as traumas of sexual and aggressive nature.

Such terms as shell shock, war neurosis, battle fatigue, combat exhaustion, and traumatic neuroses of war were in wide use through WWII in their application to psychic disorders related to active warfare. In civilians these conditions were labeled traumatic neuroses and stress response syndromes. All these terms were superseded for many by the designation PTSD, a more recent term widely thought to be an alternative for war neurosis. In fact, PTSD is not an equivalent for psychic trauma in any of the latter’s permutations. Rather, it is a pathological complication of psychic trauma from any source.

In regard to psychoanalysis, Furst (1967) underscored the point that psychic trauma was central to Freud’s early theory of neurosis. The traumatic factors of shock and disturbed mental equilibrium, with an overwhelming of the psychic apparatus, were key. Fears of being overwhelmed have been related to fears of the strength of the affects, of the drives, and of external stimulation. He further stated that the ego cannot perform its function of defense when it is overwhelmed. The distress associated with affective experience can be
traumatic, which means that it is overwhelming and can disorganize a range of psychic functions. Krystal (1988) wrote: "If the generalization can be made that stimuli can be overwhelming, then a unitary theory of trauma and pathogenesis would be secure" (p. 140).

In 1920, Freud underscored the traumatic effect of massive external stimulation. He emphasized that the sudden and unexpected influx that precludes adequate defensive preparedness blocks control and mastery and constitutes “a metaphorical rent” (De Masi, 2004) in the mental membrane that protects the organism from overstimulation, compromising the background of safety (Sandler, 1960/1987) and the “secure base” (Bowlby, 1988). This constitutes a psychic emergency which leaves the person in a traumatic state.

In the subsequent literature, many definitions of psychic trauma have been formulated (e.g., Furst, 1967; Rothstein, 1986). A broad definition was provided by Greenacre (1967): “In my own work I have... included traumatic conditions, i.e., any conditions which seem definitely unfavorable, noxious, or dramatically injurious to the developing young individual” (p. 128, italics in original).

A more specific focus was provided by Anna Freud (1967), who wrote that psychic trauma is associated with devastating and shattering experiences that result in internal disruption as a consequence of putting ego functioning and mediation out of action. She also included as required trauma criteria, a numbing of feeling, a paralysis of action ability, 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 may, at the extremes, include a breakdown, blocking or paralysis of cognitive and motor functioning often go along with affect regression (Krystal, 1988). He specified de-differentiation and resomatization, which are accompanied by interference with both verbalization and symbolization.

Dowling (1986) emphasized the psychological meaning of the traumatic experience, its organizing influence on the mental sphere, and that it plays a striking role in the individual’s further growth.

It is here asserted that annihilation-survival fantasies comprise a key psychic content of trauma, with concerns over survival, self-preservation, and safety. The key areas of concern are for the integrity of the sense of self, the intactness of the ego functions, and the level of object relations. Specific annihilation fantasies that are residuals of the traumatic experience often serve as organizing events for the given person, centering on individually configured meanings of being overwhelmed, unable to cope, invaded, merged, and imminently destroyed (Hurvich, 1989, 2003a).

The time of trauma onset has always been of significance in psychoanalysis: infantile (Krystal, 1988), age of childhood, age of adolescence and age of adulthood, which interacts with the patient’s trauma history/trauma load. Criteria have been set forth to distinguish infantile onset trauma from adult trauma (Krystal, 1988; Boulanger, 2002). An important relevant consideration here is the clinical finding that any current
traumatic experience activates all previous psychic traumas. The mechanism is hypothesized to be a regression in reality testing initiated by the anxiety accompanying the traumatic experience leading to a loss of the distinction between past and present. It is noted that the disruption following the trauma is influenced by varying degrees of the current adult onset versus the traumatic history load, with these two sources of anxiety being additive.

The Close Connection between Anxiety & Psychic Trauma

At the heart of his 1926 contribution, which took many twists and turns before he sorted out his views, Freud postulated a close relation between anxiety and psychic trauma, where a danger situation is seen as a displaced expectation of a traumatic situation, namely, the fear of a return of a traumatic moment. Freud saw the crucial transition from helplessness to expectation and defense, from traumatic response to anticipation of a potential danger, to entail turning passive into active, with a displacement from the helplessness, associated with a memory trace of a traumatic situation, onto an anticipation of what have come to be called the situations of danger: Abandonment, Rejection, Castration/Bodily Harm and Super-ego Reproach, in a developmental sequence (Freud, 1926). It is relevant to note that Freud both in 1926 and 1933 stated that when the ego is immature, it is the danger of psychic helplessness that is the most relevant.

In 1933, where he more succinctly recapitulated the 1926 revised views, Freud summarized as follows: “...I can see no objection to there being a twofold origin of anxiety—one as a direct consequence of the traumatic moment and the
other as a signal threatening a repetition of such a moment” (pp. 94-95, italics added). The most severe form of Annihilation Anxiety, catastrophic annihilation anxiety, is here considered to be manifestations of the traumatic moment.

Based on the ambiguity and diffuseness in the many uses of the psychic trauma concept, Sandler (Sandler, Dreher & Drews, 1991) has called for finding a relevant concept that could “represent the whole spectrum of traumatogenic disturbances” (p. 140). I am here proposing that the annihilation anxiety concept, and the designation of Annihilation Anxiety as a trauma marker, may answer such a call. This can allow Annihilation Anxieties to serve as a bridge between the psychoanalytic theory of anxiety and the theory of psychic trauma, both refining and further delineating Freud’s 1926 assertion that anxiety is the first reaction to helplessness in a trauma. A traumatic situation response, often associated with helplessness and panic anxiety, may induce or be a response to annihilation concerns.

For the past 25 years I have been further elaborating on the traumatic moment (e.g., Hurvich, 1989, 2000, 2003a, 2004, 2011a, b) focusing on the term “Annihilation Anxieties”, comparing it with related concepts of severe anxiety, delineating its dimensions, developing propositions (Hurvich, 2003a, 2014; Hurvich and Freedman, 2011a), and measuring manifestations of the concept both clinically (Hurvich, 1991, 2003b; Hurvich & Simha-Alpern, 1997) and empirically (Hurvich, Benveniste, Howard, Coonerty, 1993; Levin & Hurvich, 1995; Benveniste, Papouchis, Allen, & Hurvich, 1998). As of now, we
have about 45 empirical studies comparing annihilation anxieties based on questionnaires and projective test scales with a host of other measures and diagnoses (Allen, Hurvich & McGuire, submitted).

**CHARACTERISTICS OF ANNIHILATION ANXIETIES**

Definitional components of annihilation anxieties can be set forth as a set of Propositions: Annihilation experiences and anxieties are universal in early childhood, where psychic dangers are regularly experienced as traumatic. They 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 dimensions and sub-dimensions; may occur in pre-symbolic 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. The study of annihilation anxieties in relation to the basic danger series has both theoretical and clinical advantages, especially for understanding traumatic, anxiety, phobic, psychosomatic, addictive, narcissistic, borderline, and psychotic manifestations. A detailed presentation of these propositions is in Hurvich (2003a).

**Terms Related to Annihilation Anxieties Proposed by Earlier Authors**

Survival-related clinical reports are abundantly found in the works of classical, object-relational, and self psychological writers, but are under-represented in major theoretical formulations on anxiety. An exception to this
underrepresentation is the closely related concept of psychic trauma, broadly summarized by Furst (1995), Rothstein (1986), and Auchincloss and Samberg (2014). In addition to Freud’s (1926) traumatic situation of helplessness already described, annihilation anxieties are closely related to automatic anxiety (Freud), instinctual anxiety (A. Freud), primitive agonies (Winnicott), psychotic anxieties (Klein; Winnicott), organismic panic (Pao), emotional flooding (Volkan), nameless dread (Bion), and disintegration anxiety (Kohut). These authors, in their various ways, have underscored concerns over psychic dissolution and fragmentation of the self, and of the ego functions as well as survival apprehensions as the basic danger facing psychotics (Karon & Vandenboss, 1981; Frosch, 1983; Teixeira, 1984). Expectably some of these formulations have been further elaborated and refined. For example, Schur (1953) held that rather than automatic anxiety, there is an automatic ego response to the person’s view that he is facing a traumatic situation.

Rather than describing annihilation anxieties as one among a number of anxiety terms to complement Freud’s basic dangers, I am proposing Annihilation Anxieties as a Fifth Psychic Danger. The justification for this proposal is further elaborated in another article in preparation (Hurvich, in preparation).

Andre Green (2007) wrote that issues such as fears of annihilation, primitive agonies and nameless dread are mentioned “in relation to theory with regard to a hypothetical appearance during the childhood of patients, but their clinical description in the adult has been given little detailed attention in clinical psychoanalysis” (p. 42, italics added). Congruent with this view, I have utilized
the details of these authors in conjunction with a more general literature review to arrive at the seven Annihilation Anxiety dimensions to be elaborated below.

**A Proposal for Including Annihilation Anxiety as a Fifth Danger**

Based on the assumption that overwhelmed helplessness can at some point be anticipated, I am asserting that Annihilation Anxiety qualifies as a basic danger. The basic danger in Annihilation Anxiety is *psychic survival threat*, which is experienced as a current hazard or as an apprehension of an impending calamity. It is here considered to be the first basic danger, of which the later ones, beginning with the loss of the object, have been described by Freud as derivatives and partial transformations. Support for this proposition can be found in Freud's 1926 monograph on anxiety, and in the many terms included in this paper and employed by a wide range of psychoanalytic writers to characterize severe anxieties, as detailed above. A similar proposal for the inclusion of annihilation anxieties as a fifth danger in the basic danger series was made by Jacobson (1983).

There are various ways in which annihilation anxieties can be compared and contrasted with the other basic dangers. Freud (1926) described each of the four dangers in terms of loss: of object, of love, of genital integrity, and of superego support. Annihilation Anxieties, in this regard, can be seen as concerned with a loss of the capacity to function and/or exist.

Clinical data indicate that annihilation anxieties may be found in conjunction with any of the other dangers, or may be triggered as a secondary
response to them. The latter can occur when the anxiety associated with one of the other dangers reaches a sufficient intensity, or when one (or more) of the other dangers is associated with disorganization of ego functions or self-representations. For example, feelings of annihilation can result when the person experiences loss of love as a negation of his or her existence (Waelder 1967; Lichtenstein 1964). An example where annihilation concerns are triggered in the wake of incest and genital anxieties: “I felt the genital penetration as a burning sensation that was like an infected shot, like father had poisoned me” (Hurvich, 2011).

Annihilation anxieties constitute significant dangers that may or may not be reducible to the four typical dangers. The former are associated with survival concerns that have been described as overwhelming and as involving fears of merger, disintegration, and the like. While all the basic dangers may be experienced as calamities in early childhood, basic dangers are later on more likely to constitute calamities when they are experienced as threatening survival. Helplessness is also more likely to trigger annihilation anxieties when it occurs in the context of a particular ego vulnerability.

This formulation retains a place for the traumatic moment as an overwhelming experience associated with disorganization and uncontrolled anxiety. To become part of the basic danger series, the annihilation content must be *anticipated* and be associated with *controlled* anxiety as it is true of the other basic dangers.
Seven Annihilation Anxiety Dimensions & Sub-Dimensions

These Dimensions involve different degrees and qualities of helplessness, and variations on how central the threat is anticipated to be for ego functioning, for the integrity of the self, and for the stability and predictability of the person’s object relations. As already stated, the seven Dimensions are related to and sometimes are triggered along with Freud’s (1926) basic dangers, but may also go beyond them. In their briefest designation, the Annihilation Dimensions are:

1. OVERWHELMED
2. MERGED
3. TRAPPED
4. DISORGANIZED
5. ABANDONED
6. INVADED
7. DESTROYED

Each of the dimensions is more at the level of clinical generalization while the sub-dimensions more reflect the level of clinical observation.

A detailed consideration of references further delineating these dimensions are: Hurvich (2004, pp. 58-63) and Hurvich and Freedman (2011b, pp. 107-110).
Table 1. Dimensions and sub-dimensions of annihilation anxiety

<table>
<thead>
<tr>
<th>Overwhelmed</th>
<th>Overstimulated</th>
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<tbody>
<tr>
<td>Buried Alive</td>
<td>Smothered</td>
</tr>
<tr>
<td>Drowned</td>
<td>Loss of Control</td>
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<tr>
<td>Flooded</td>
<td>Inability to Function</td>
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<tr>
<td>Swept Away</td>
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<td>Engulfed</td>
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<table>
<thead>
<tr>
<th>Merged</th>
<th></th>
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<tbody>
<tr>
<td>Absorbed</td>
<td>Devoured/Swallowed</td>
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<table>
<thead>
<tr>
<th>Trapped</th>
<th></th>
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<tbody>
<tr>
<td>Cornered</td>
<td>Caught</td>
</tr>
<tr>
<td>Immobilized</td>
<td>Efforts to Escape (In Dreams)</td>
</tr>
<tr>
<td>Confined</td>
<td></td>
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<table>
<thead>
<tr>
<th>Fragmented: Self/Ego</th>
<th></th>
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<tbody>
<tr>
<td>Split off</td>
<td>Going Insane</td>
</tr>
<tr>
<td>Disappearing</td>
<td>Immobilized</td>
</tr>
<tr>
<td>Dehumanized</td>
<td>Melting</td>
</tr>
<tr>
<td>Evaporating</td>
<td>Mortified</td>
</tr>
<tr>
<td>Falling Apart</td>
<td>Shattering</td>
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<table>
<thead>
<tr>
<th>Abandoned</th>
<th></th>
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<tbody>
<tr>
<td>Cast out</td>
<td>Falling</td>
</tr>
<tr>
<td>Cut off</td>
<td>Excluded</td>
</tr>
<tr>
<td>Deserted</td>
<td>Rejected</td>
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</table>

<table>
<thead>
<tr>
<th>Invaded</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Body Complaints</td>
<td>Persecuted/Tortured</td>
</tr>
<tr>
<td>Intruded upon</td>
<td>Mutilated</td>
</tr>
<tr>
<td>Penetrated</td>
<td></td>
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<table>
<thead>
<tr>
<th>Destroyed</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Killed</td>
<td>Catastrophic Mentality</td>
</tr>
<tr>
<td>Poisoned</td>
<td>Negated</td>
</tr>
<tr>
<td>Demoralized</td>
<td>Nothingness</td>
</tr>
<tr>
<td>World Destruction</td>
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While these psychic contents go a long way in defining annihilation anxieties, there is also a psychostructural aspect, related to ego strength, that
plays an important role in differentiating, for example, when “going to pieces” does or does not lead to “falling apart” (Epstein, 1998). These structural components are set forth as variables in relation to traumatic (annihilation) and signal anxieties (Hurvich, 2004).

**Table 2.** Structural components of traumatic Anxiety/annihilation anxiety and signal anxiety

<table>
<thead>
<tr>
<th>TRAUMATIC ANXIETY/ANNIHILATION ANXIETIES</th>
<th>SIGNAL ANXIETY</th>
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<tbody>
<tr>
<td>Desymbolized</td>
<td>Symbolized</td>
</tr>
<tr>
<td>Uncontrolled</td>
<td>Controlled</td>
</tr>
<tr>
<td>Intolerable</td>
<td>Tolerable</td>
</tr>
<tr>
<td>Disorganized</td>
<td>Organized</td>
</tr>
<tr>
<td>Somatized</td>
<td>Desomatized</td>
</tr>
<tr>
<td>Primary Process</td>
<td>Secondary Process</td>
</tr>
<tr>
<td>Reality testing &amp; Reflective Function</td>
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<tr>
<td>Affect Tolerance</td>
<td></td>
</tr>
<tr>
<td>Anger</td>
<td></td>
</tr>
<tr>
<td>Regression</td>
<td></td>
</tr>
<tr>
<td>Secondary Anxiety</td>
<td></td>
</tr>
<tr>
<td>Trust</td>
<td></td>
</tr>
<tr>
<td>Assimilability of the Experience</td>
<td></td>
</tr>
<tr>
<td>Arousal of Previous Disturbing Memories &amp; Unconscious Fantasies</td>
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</tbody>
</table>
Having highlighted the dimensional approach to Annihilation Anxieties, I want to illustrate how detailing the Dimensions allows a more specific delineation of the clinical manifestations under scrutiny, such as, whether the emphasis, in a given case, is on the threat of Invasion, or the threat of Abandonment, etc. Similarly, in relation to the sub-Dimensions, when the major relevant Dimension is Overwhelmed, is the fantasy about being Smothered, Swept away, or Overstimulated? When the apprehension is about being merged, are there indications that this is serving as a defense against the terror of Abandonment, or something else (Lewin & Schulz, 1992). This elucidation also has therapeutic implications. For example, containment and reflection in patients whose invasion apprehensions are particularly strong are especially appropriate forms of intervention, while confrontation and interpretation would be more likely to trigger substantial defensiveness. Under other circumstances, the reverse could be true.

*The dimensional approach to Annihilation Anxieties complements the trauma concept by providing greater specificity concerning the anxieties involved.*

In addition, dimensionalizing Annihilation Anxieties allows the raising and exploring of questions that have theoretical, diagnostic and therapeutic implications. For example, to what extent and under what conditions are high penetration fears associated with riddance mechanisms such as externalization and projection? To what extent and under what conditions does the repeated use of these defenses interfere with containment, identification with the
analyst, and taking in the analyst's interventions? Under what conditions do
annihilation anxieties in both patient and analyst influence manifestations of
transference and countertransference? What are the relations between a
wish/fear of merger, of penetration, and of being overwhelmed? What are the
relationships, in a given patient and for groups of patients, between fears of
falling forever, fears of shattering into bits, and fears of fading away? How do
these relationships connect to such factors as specific traumatic history,
dominant unconscious fantasies, high or low levels of aggression, high or low
ego strength in general, and particular ego functions such as stable reality
testing and capacity for synthesis? In relation to what considerations do fears
of catastrophe, merger, and penetration constitute survival concerns, and when
do they not?

*Annihilation Anxiety Dimensions and their Interrelationships*

As an example of these issues in a specific patient: “The feeling of being
trapped for me is closely associated with the feeling of being invaded. They go
together in my mind. It’s when my parents did not recognize my need because
their need was so strong that I had to try to fulfill my parents’ need so I could
win their love (mother) and avoid their wrath (father). It also includes a sense of
loss of control and feeling obliterated”.

Here from the context it was possible to see how the activation of the
Annihilation Anxiety components was associated with a radical (though
temporary) interference with her sense of agency and the experience of
temporary obliteration of her sense of self. Following the patient’s associations
led to the connections in her mind between being trapped, then invaded and then loss of control, and then loss of the sense of agency and then to a feeling of being obliterated. This is an example of working through the components of a traumatic reaction from the associative network of a specific traumatized patient. Relevant here is Wurmser’s (1980-81) concept of specificity. The patient expressed a sense of relief and decrease in the level of those anxieties on the basis of our highlighting their interrelationships.

**Annihilation Anxieties & Psychopathology**

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. 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, Weiss, Socrarides, Max Stern, Mack, Gaddini, MacDougall and Wurmser have all described annihilation anxieties in relation to a whole range of additional psychopathologies.

Another key distinction is between **neurotic and psychotic anxieties**. The former is focused on Freud’s basic dangers and in the latter the person
cannot take survival for granted, a circumstance which renders the person vulnerable to uncontrolled anxiety/panic (Little, 1958).

In another well known position, Brenner re-defined Freud’s basic danger series as the “calamities of childhood”, while excluding the traumatic moment based on his assessment that Freud’s evidence for this construct was inadequate (Brenner, 1953; Hurvich, 1997). Recognizing this difficulty, Cohen (1980) delineated trauma paradigm, where traumatic experiences tend to lead to a consequentially modified psychic organization dominated by compulsive repetition functioning, which results from a sufficiently disorganizing stimulus (external or internal) eventuating in a “radically new mental organization” (p. 421).

Kohut (1984), on the other hand, characterized disintegration anxiety as "the deepest anxiety man can experience," and that none of the forms of anxiety described by Freud are equivalent (p. 16). But he formulated disintegration anxiety as an alternative to Freud’s basic danger series, rather than integrating it with the basic dangers (Kohut, 1984). Kohut is emphatic that his formulation of disintegration anxiety is not readily integratable with Freud’s views on the basic dangers. As he wrote, “While there is some truth in the statement that all the forms of anxiety enumerated by Freud, and especially the one he designated as fear of loss of love of the love object, contain admixtures of disintegration anxiety, the attempt to establish a conceptual equivalence between Freud’s categories and disintegration anxiety as understood by self psychology results in a tour de force with ambiguous results”
(Kohut, 1984, p. 213, italics added). It should be clear that the concept of annihilation anxiety elaborated in this paper is explicitly related to the basic dangers of Freud, as part of an expanded danger series, to the enrichment of both, as referred to above. Nevertheless, Kohut’s elaboration of disintegration anxiety deserves recognition.

More recently, Wolf (1995) has reformulated the central component of psychic trauma from his understanding of self psychology as an insufficient amount of attunement with the baby. This formulation appears to be close to “cumulative” (Khan, 1963) or strain trauma, but neither of the latter are on the same level as shock trauma.

Another related concept, nameless dread (Bion, 1962a), is discussed in relation to death anxiety below.

**Prevalence of Annihilation Anxieties: The Overwhelmed/Disorganized (O/D) Syndromes**

There are a number of widespread psychopathological conditions, all of which demonstrate central annihilation anxieties in spite of other differences. These conditions are here termed Overwhelmed/ Disorganized (O/D) Syndromes, and they include: *Panic, Nightmares, Suicidal Crises, Fulminating Psychoses, & Psychic Trauma* (Hurvich, 2012).

All

- are characterized centrally by annihilation anxiety dimensions (see pp. 12-14);
• have the features of psychic trauma and/or PTSD (see DSM-V for PTSD criteria);
• involve feeling overwhelmed and are described as intolerable, characterized by a sense of helplessness associated with an inability to establish a coherent response and to function adaptively, and may include feelings of disruption, disorganization, loss of control, and paralysis. This is tantamount to a regression in the evaluation of the danger and in the response to the danger (Schur, 1953). Patients describe such experiences as of being flooded, buried, submerged, drowned, deluged, engulfed, crushed, immobilized, and overpowered;
• entail regressive disintegration, with a wide range of recovery times.

The ideational aspect involves a dynamic fantasy content that is found at varying levels of symbolization/mentalization. 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).

**Annihilation Anxieties found at Different Levels of Mental Organization**

Annihilation-survival-related Anxieties reflect residues of and intrapsychic reactions to traumatic experiences, *manifestations of which can be found at different levels of mental organization*. These I have described as: (1)

**Catastrophic Annihilation Anxieties**, the most severe and clinically
consequential level, characterized by disruptive affect arousal and inhibition of function, and include but are not limited to the O/D Syndromes just described. The criteria that identify the level of Catastrophic Annihilation Anxieties are: pervasive feelings of uncontrolled (panic-like) anxiety, reflected in random responses, prominent somatic features and substantial primary process functioning (Schur, 1953), described by patients as intolerable, accompanied by obligatory attempts to escape the pain.

There is regressive disorganization in reality testing, especially in the blurring of the distinction between past and present (Schur, 1953), and in the capacity for integration, as well as in a shift toward primary process/magical thinking. In the Catastrophic Annihilation Anxieties level, the capacity to function may disappear for varying lengths of time (“Since this week-end, I have been unable to function in my work”). And/or, the integration of the sense of self has undergone regressive decrement (“I feel like I don’t know who I am anymore and I can barely function”). At this Catastrophic level of Annihilation Anxieties, feeling Overwhelmed is associated with functional decrement and tends to be a dominant feature.

The Catastrophic level of Annihilation Anxieties centrally includes psychostructural characteristics which go beyond and modify the psychic content, as well as reflect signs of mental disorganization. The key affects are fright, terror, shock and dread. For example in describing two different ego states a lower-level borderline patient made the following comparison:

“Stepping out of myself” is kind of like being an observer but also a kind of
separation from myself. It’s similar to the experience of floating above my body on the ceiling.” [It may be recognized here that the patient is describing a frequent variety of dissociation.]

“The hall of mirrors experience, by contrast is a complete splintering of my mind. What I see is incomprehensible because it is all dissected and broken up. It is like light refracting off a prism. It is fractured into so many angles and it goes on for infinity, with a fear of no return. It is terrifying.” This description of the catastrophic level echoes A. Freud’s earlier characterization of psychic trauma as devastating and shattering experiences.

(2) At the next level, which is less severe than the Catastrophic, protection against Annihilation Anxieties is a key feature of the psychic defense system, which at its extreme is organized around life-experience-limiting inhibitions and phobias, with a high likelihood of substantial somatic symptoms (Farber, Jackson, Tabin, & Bachar, 2007). This level of Annihilation Anxieties appears to have significant points in common with Steiner’s (1993) psychic retreats.

(3) At an even higher level of functioning, a person may experience Annihilation Anxieties occasionally reflected in the specific apprehensions mentioned above (overwhelmed, disorganized, etc) that are less likely to be experienced as intolerable, and are not associated with high affect arousal or a substantial degree of mental disorganization. While the clinical literature (Freud, 1926; Brenner, 1982) has emphasized fears of abandonment, rejection,
bodily harm and pangs of conscience, Annihilation Anxieties may be triggered along with any of these or separate from them as already illustrated.

**Fear of Death and Annihilation Anxieties**

Freud (1923, p. 58) held that death anxiety cannot be unconsciously represented and is related to the fear of castration. The latter has both theoretical and clinical support, but neither view leaves enough room for fears of death as a primary phenomenon. On the other hand, Piven (2004), beginning his analysis of death anxiety in Freud’s work where most writers leave off, examined 50 of Freud’s texts and showed that his views on death were much more complex. Piven agrees with Becker, Yalom, Lifton and others that death anxiety is the most profound human apprehension, that it plays a considerable role in psychic life, and that it is strenuously and widely defended against. For more recent treatments, see Razinsky (2013) and Blass (2014).

Klein (1948/1975) did find unconscious representations of death which were reflected in bad and persecutory objects. Eissler (1955) claimed that fears of future death and annihilation anxieties can be distinguished. He illustrated the distinction in patients with senile dementia facing surgery who showed annihilation fear but no fear of death. An absence of the latter, claimed Eissler, was the result of cerebral pathology having resulted in loss of anticipatory capacity. The possibility of discomfort and pain associated with scheduled surgery did lead to relevant emotional reactions since these were still included in the biological present, the earliest time category experienced by the child (Spielrein, 1923, cited in Eissler, 1955). Max Stern (1968) formulated the fear
of death as a “repetition of a previous situation in which the ego experienced something like its own annihilation” (p. 4).

Patients high in catastrophic annihilation anxiety are often claimed to have an unconscious belief that suffering will protect them from the violence of the internalized traumatic object. The person is trapped between the desire for relief and the fear of it (Lopez-Corvo, 2006).

Two major aspects of death anxiety have been described as nameless dread and depressive affect over loss. A clinical hypothesis is that nameless dread will dominate when there is a preponderance of negative introjects, while depressive anxiety will be stronger when positive introjects are greater. When nameless dread has been activated in a psychotic patient, the latter will attempt to avoid re-experiencing the panic anxiety by resisting efforts to explore his psychotic mechanisms (Bion, 1962b).

**Clinical Examples**

The following case vignette is offered as illustrative of Annihilation Anxiety manifestations. It is a selective and highly condensed report which demonstrates symptoms that reflect central annihilation/survival concerns. Defenses against mourning were found to serve as major resistances, which were attempts to protect against annihilation anxieties.

The patient, a 40 year old, white married, employed male, the first of two boys in a lower middle class family, had been in analytically oriented psychotherapy for many years. His major concern when he started treatment with me was that he felt unable to control his hostile outbursts and that this
would result in his fiancé leaving him. He presented a continual preoccupation with feelings of being destroyed as a person. This meant for him an inability to grow psychologically, to be creative and to approach his potential. He relied heavily on the defense of splitting, had a low and vulnerable self esteem and pathological self esteem regulation, showed poor impulse control especially of aggression, and primitive internalized object relations. My diagnosis was Borderline Personality with central narcissistic, obsessive-compulsive and paranoid features. He could also be characterized as a narcissistic personality operating at an overt borderline level (Kernberg), or as a psychotic character (Frosch).

Symptomatically, he reported obsessive ruminations and compulsive rituals. One involved an obligatory urge to poke his tongue into one of his teeth, which he did until he believed he had loosened it. He would then obsess over whether or not he had destroyed the tooth. An anxious visit to the dentist resulted in his being reassured that the tooth was intact, and in being advised not to poke at it further— which he proceeded to do anyway, and the cycle would repeat. (Wilson & Malatesta, 1989).

A related pattern unfolded as follows: If he accidentally dropped his camera, or bumped his arm, he would then intentionally drop the camera again, or willfully bump his arm. This was an attempt to make it come out better. This time, he hoped, the camera would not be damaged, or his arm would not be hurt. By repeating an act of damage, he would (magically) undo the damage. His associations around these issues revealed attempts to undo
the apprehension that he had been irreparably damaged by his parents. The doing and undoing was a symptomatic reflection of his preoccupation over whether he had or had not been destroyed.

An undoing defense was also central to a stated wish to kill his parents. He said: “The act of hate is a way of ridding myself of what they've done to me. It's a way of defending myself against my parents. If I could kill them, then I could prove to myself that they did not destroy me. It would show that I am strong enough to defend myself, and it disproves the feeling of being destroyed. It means I'm strong, not an incompetent, worthless freak. Hate is for me a way of self-enhancement”

The patient further elaborated the central place of revenge-hatred as follows: “The passion and craving to destroy my parents was as important to me in childhood as sucking, the strongest childhood desire. It’s like an orgasm, it overwhelms all other desires. I want to release and discharge it. If I had killed them when I was child, I could have grown as a person.”

He described his parents as never having acknowledged his existence. When he was little, his mother talked about him to her friends in his presence as though he was not there. During school years, his father downgraded his interests and efforts because he did not follow the latter's religious ideas. He had few friends, and remembers his developmental years as a disaster. He felt humiliated, rejected and destroyed, the latter because he believed his parents had crushed his ability to grow mentally, and to express himself creatively. Early experienced lack of trust, failure of differentiation and inability to
separate, and blocked mourning, led to repeated enactments as victim or aggressor, reflecting the central sadomasochistic and paranoid personality features.

This patient, with major preoedipal fixations, dominant primitive internalized object representations and substantial ego function weaknesses, also demonstrated a number of related, maladaptive and dangerous action patterns that were manifestations of vengefulness. These acts of revenge threatened his key relationship, his friendships and his health. Although he gained a clear awareness of consequences, and there was an uncovering and clarification of the bases for the patterns, the patient continued to repeat them, and twice quit treatment (later to return) when he felt that remaining in therapy might result in his giving up these behaviors. The revenge motivation had become strong in adolescence, when he developed ways of doing things that would hurt other people. Revenge served as a central self-esteem regulator. It was a survival defense, protecting him against feared annihilation, as the parricidal wish demonstrated.

On a deeper level, there was the specific fear of non-existence. This is consistent with his uncontrolled rage when he would experience a loss of eye contact. Also consistent is the ruminative-repetitious going over of his complaints and angers toward his parents, as these were encoded in his inner world. Developmentally, I understood this pattern as related, among other things, to the fear of disappearance from the mind of the parent, specifically, his massively unattuned mother. Fantasies of incorporating his father’s penis
to merge with him and steal his strength also were prominently seen in the material.

As the patient put it:

“I want to bite my father’s prick to get power from him. My teeth symptoms get worse when I try to do things on my own, things I like to do. And I want to get into his body: destroy him, mutilate him, give him great pain. But I also want to live in his body—to get his warmth, protection and strength. I’m one with him, I’m in with him. I want to lose my identity and gain his potency, strength and power. It’s the symbolism of the womb”.

Reference to the heightening of the teeth symptoms when he originates action in line with his own interests suggests that such intentions activate the conflict over destroying and being destroyed. The desire to feel powerful and secure was mediated through a more primitive fantasy of incorporation rather than through a developmentally more advanced identification with his father’s behavior and interests. In addition to a merger wish-tendency, a selective identification was blocked by the father’s hostile rejection of the patient. The dental symptom, which involved a self initiated assault on the integrity of his own tooth, can additionally be seen as an enactment of a talion punishment for the wish to bite off the father’s penis.

The inability to mourn his hated childhood also interfered with working through, both of which require a letting go, bit by bit. While he did show some important improvement in autonomous functioning and sublimation, both of
which served as reassurances against having been destroyed, he avoided mourning. The defensively influenced failure to mourn his dreadful childhood memory-fantasies was importantly related to the annihilation danger. A realistic facing of his fantasy-elaborated past would require the recognition that the damage only could be partially ameliorated, confirming that they did destroy him. Mourning would threaten the fantasy that time had not passed, and that he was still a child who could get what he needed from his parents and not be destroyed. This constituted the heart of the resistance in therapy, a key effort to protect him against his central annihilation terror.

Mrs. T.
A 44 year old woman from a strict, moralistic family was the fifth child of seven, whose mother was a seriously disturbed alcoholic and whose father was a strict authoritarian, who yelled at her brothers, had disgusting habits, and she felt terrified of him, though she claimed they had only a minimal relationship. Much of the emotional nutriment she got was from her siblings. She demonstrated rigid though weak and permeable ego boundaries with a vulnerable repression barrier. She experienced near panic anxiety and annihilation anxieties when her defenses were compromised. She was plagued by severe obsessive worries and undoing compulsive rituals. The obsessions were of mortal sin associated with fears she may have willfully prolonged sexual thoughts, and of contamination fears of the deadly poisonous potentials of cleaning powders and tiny bits of glass.
A typical example: finishing her habitual second pre-dinner martini she noticed a chipped lip on the oil cruet when the waiter brought her salad. She wondered if bits of glass had been accidentally broken off and had fallen into the salad of a customer at another table. She then experienced an irresistible urge to inform the waiter, explaining that if she did not, any harm that might befall the other customer would be her fault, that she would be a murderess. The patient insisted to me that she experienced no concerns that she would be poisoned: only the hapless stranger she was trying to protect. In spite of the feeling she must act, the patient urgently wanted to be told she didn’t need to do anything. Any encouragement that she act on the obsession would trigger panic level anxiety.

As a child, the patient had been preoccupied with death. She described fears of being killed by lighting, fantasies of being in a white casket and of people looking at her corpse. She read the Obituary column daily, and was especially interested in reports of a child dying. Her fear of death extended to fear of after death, that she would burn perpetually because of her sins. The panic states were dated by her to have started near the end of her senior year of college, related to a conflictual sexual temptation. The prospect of returning to the parental home was unpleasant, due to mother’s insistence that the patient do so many chores, and more generally to the mother’s ways, which the patient found intolerably annoying.

She was fascinated with accidents, as an adolescent would run to any accident scene, she reported experiencing a thrill in seeing people carried on
stretcher. She worried that her younger brother would be killed on his scooter, and that any physical symptom mentioned by her mother meant that the mother soon would die.

Prior to her psychotic break, she had suspicions that her husband may be a thief or a murderer, that he may have been married before, though he vehemently denied it. Most of this patient’s worrisome obsessions were in the form of “maybe”, but these were processed as fact.

On several occasions, the patient had similar fears about accidentally poisoning her mother. These symptoms guarded her from, among other things, her fears of intimacy in her five-year unconsummated marriage. Secondary gains from the symptoms were reflected in the patient’s anxious insistence that the husband do all the shopping, cooking, dish washing and cleaning, due to her contamination fears.

Following pressure to complete a job at work, the patient expressed to me: “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 like I’m going to crack up. At my job I can’t do a thing: I feel I just can’t go on. It’s destroying me.”

Not long thereafter, the patient went for a medical check due to abdominal discomfort. Her physician told her she had “toxic hepatitis”, and would have to stop all alcohol intake. In a flash of psychotic insight, the patient concluded: “toxic…POISON!…B (husband) is poisoning our liquor!” She went into a several month-long paranoid state focused on apprehensions of his
poisoning the food as well. The patient showed prominent features of a psychotic state, but I did not hospitalize her, and she continued to interact with the husband. When she believed the husband had poisoned the tapioca pudding, she confronted him with her surmise, and asked for his reassurance. He readily gave it, but she then would accuse him of lying. Prior to the psychotic episode, she had accused the therapist of condoning her confession of mortal sin, and felt it was her duty to report me to “Rome”.

The obsessive-compulsive defense structure had eroded and the patient fell back on paranoid tendencies. Prior to the break, the patient claimed that she was spending 90% of her waking time focusing on her obsessive thoughts, much of that being whether she had committed mortal sin, sexual and aggressive. While already in an anxious state following the stress at work, the medical diagnosis triggered additional regression and a turning around of the threat: The husband-mother had now become the source of the annihilatory danger.

In the therapeutic situation, she had used argumentativeness in the service of distancing from me. Attempts to analyze the narrowness and suspiciousness threatened this patient’s sense of survival. In the therapeutic situation, she used argumentativeness for the same distancing purpose, while under the sway of sexual and aggressive fantasies. She demonstrated a vulnerable repression barrier and the triggering of annihilation anxieties recently, when her defenses were compromised.

In the framework of a supportive therapeutic environment, careful
attempts to analyze the narrowness and suspiciousness threatened this patient’s sense of survival. The recalcitrant resistances, the decrement in functioning and/or the disorganization that followed these interventions had been offered with adequate preparation, timing and tact. On further exploration, I concluded that the resistance was often underlain by annihilatory anxieties, and that the decrement/disorganization was a reflection of defensive failure to protect against the survival-related apprehensions. This was part of the original stimulus for my interest in exploring this topic, clinically, theoretically and empirically: Symptoms, beliefs, affect states, and behaviors are especially resistant to change when they are defending against annihilation anxieties (Hurvich, 2003). The previously reported case also illustrates annihilation influenced recalcitrant resistances.

The extension of the danger series detailed here underscores anxieties that are universal but are more often observed in disturbed individuals. Though intricately associated with Freud’s four typical dangers, survival-related apprehensions warrant their own standing as a basic or typical danger. This paper has detailed the prevalence of Annihilation Anxieties in the psychoanalytic literature and provided a delineation of definitional features. A comprehensive elaboration of the basis of Annihilation Anxieties as a fifth danger is currently in preparation (Hurvich, 2015).
REFERENCES


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