NEW DEVELOPMENTS IN THE THEORY AND CLINICAL APPLICATION OF THE

ANNIHILATION ANXIETY CONCEPT

Marvin Hurvich, Ph.D.  Final


My interest in annihilation anxieties (AA) goes back to a 1980 clinical observation that recalcitrant symptoms in more disturbed patients are often underlain by defended anxieties concerning annihilation and threats to survival. Analytic scrutiny revealed that these anxieties included apprehensions of being overwhelmed, dissolved, invaded or going insane. In addition to constructing a research instrument to measure the extent of these anxieties in clinical populations (Hurvich, 1989; Benveniste, Papouchis, Allen, & Hurvich, 1998; Hurvich, Benveniste, Howard, & Coonerty, 1993; Hurvich & Simha Alpern, 1997; Levin & Hurvich, 1995), I embarked on an intensive study of the psychoanalytic literature that revealed a consequential incongruity concerning annihilation fantasies and anxieties (Hurvich, 2003 a). On the one hand there were hundreds of references to the correlates of survival-related apprehensions. On the other, formulations of such anxieties tended to be relatively undeveloped, and accorded little conceptual status in standard current mainstream theoretical works. Recent compendia of psychoanalytic theory and practice (Goldberger, 1996; Gray, 1994; Moore & Fine, 1995; Nersessian & Kopff, 1996) and Person, Cooper & Gabbard (2005) rarely mention these phenomena, or refer to them only in passing. I concluded that an important set of anxiety contents and experiences were either being overlooked or remained undeveloped in serious main-stream theorizing. Although these compendia did deal with psychic trauma, a closely related concept, they neither linked psychic trauma to the psychoanalytic theory of anxiety nor reached any kind of consensus regarding its definition. Exceptions include the work of H. Krystal on Massive Psychic Trauma (1988) and volumes edited by Furst (1967), and Rothstein (1986), among others. A recent statement by Andre Green (2006) is congruent with my observation that there has been a failure to develop the implications of annihilation anxieties. Green 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) [emphasis added].

In 1926, Freud wrote, concerning his evocative concept of the “traumatic moment,” “Anxiety is the original reaction to helplessness in the trauma and is reproduced later on in the danger situation as a signal for help” (1926, pp. 166-7) [emphasis added]. The anxiety that Freud refers to here reflects all the earmarks of terror, or of what some writers had been referring to as annihilation anxiety (Little, 1958). This connection further motivated me to look for ways to interrelate, and additionally connect anxiety theory and trauma theory. In previously published work, I have presented a detailed consideration of the annihilation anxiety concept (Hurvich 1989, 1991, 2000, 2002, 2003 a & b, 2004). The current chapter highlights my specific contributions to the construct, the writers whose ideas I utilized, elaborated, and attempted to connect, and the presentation of new applications that explore annihilation anxiety as a process variable in a psychoanalytic therapeutic framework.

**MY CONTRIBUTIONS**

Here are what I believe to be my additions to psychoanalysis in the area of anxiety theory:

1). A specification of six annihilation anxiety Dimensions and sub-Dimensions, which highlights central components and major manifestations of these survival-related fantasy contents/anxieties. I consider the bringing into focus of these survival-related apprehensions to be part of this contribution. The Dimensions comprise a range of psychic dangers associated with threats to the sense of safety, and specifically, to mental survival, to apprehensions over being destroyed, being unable to function, to self cohesion, and to fears over intimacy in interpersonal relations. These six overlapping Dimensions are at the level of clinical generalizations. They provide a succinct framework that highlights major areas under which most of the clinical observations regarding survival apprehensions may be included. Psychoanalytic writers
typically have specified one or another of the manifestations of survival anxieties (Hurvich, 2003 a), but, rarely, a series (viz., Winnicott, 1974; Laing, 1959).

I have also related the Dimensions to the famous four basic dangers (Freud, 1926; Brenner, 1982), and have claimed that annihilation fantasy contents and anxieties may go beyond these four to include states of being Overwhelmed, Merged, Disorganized, Invaded and Destroyed, which may be triggered along with any of them as secondary reactions (see Proposition 14, Hurvich, 2003 a). This may be based on the disorganization of self or of ego functioning due to the intensity of the initial anxiety, or when the initial anxiety elicits additional frights, i.e., secondary anxiety (Hurvich, 1997; Schur, 1953). Freud (1926) described each of the four dangers in terms of loss: of object, of love, of genital integrity, and of superego support. Annihilation fantasies and anxieties can, in this regard, be seen as concerned with a loss of the capacity to function and/or exist. There is also an important contrast here. The four previously recognized basic dangers center on the anticipation of being harmed by an avenging external or internal other, which is what leads to fear of the anticipated loss of the object, etc. While annihilation anxieties can also be engendered by apprehensions of being threatened by the retaliatory intentions of others, they are uniquely concerned with threats to, or disturbances of, the capacity to function or to exist. In this regard, Freud added that the real essence of the danger goes beyond the loss of object and involves, for the infant, intolerable tension which he/she is unable to alleviate alone (1926, p. 137; see also, Schur, 1953, p. 71).

The Dimensional approach 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 are especially appropriate forms of intervention.
(while confrontation and interpretation would be more likely to trigger substantial defensiveness) in patients whose invasion apprehensions (Dimension 4) are especially strong.

Dimensionalizing annihilation anxieties as just described 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? (Hurvich, 2003 a, pp.605-6).

2). A second contribution is proposing annihilation anxieties as a bridge between the psychoanalytic theory of anxiety and the psychoanalytic theory of psychic trauma, both refining and further delineating Freud’s 1926 assertion that anxiety is the first reaction to a trauma. This is also consistent with Compton’s (1980) view that the traumatic state was always at the heart of Freud’s anxiety theory. Relevant here is the proposal that annihilation anxieties constitute psychic trauma markers. And, conversely, that experiences of psychic trauma increase annihilation fantasy apprehensions. Thus, annihilation anxieties are centrally involved in the experience of psychic trauma, and comprise major traumatic residua (Hurvich, 2003 a, p. 591). A traumatic situation response, often associated with helplessness and panic anxiety, may
induce or be a response to annihilation concerns. This is supported by frequent reports from panic attack victims regarding fears of going crazy, losing control and/or dying (Hurvich, 2002, 2003a).

I am further proposing that this elaboration of the annihilation anxiety concept, and the designation of AA as a trauma marker, answers Sandler’s (Sandler et al., 1991) call for finding a relevant concept that could “represent the whole spectrum of traumatogenic disturbances.” The dimensional approach to Annihilation Anxieties complements the trauma concept, by providing greater specificity concerning the anxieties involved.

3). A third contribution builds on the two propositions just delineated. This is a proposal to expand the basic danger series to include annihilation apprehensions, while retaining the distinction between a traumatic situation and a danger situation.

Once the trauma has occurred, experiences of being overwhelmed, a signature of the traumatic moment, subsequently can be anticipated And the anticipation itself constitutes a danger situation. In addition, when the affective component is controlled and attenuated (Hurvich, 1996), it is consistent with a key definition of signal anxiety: a “recognized, remembered, expected situation of helplessness” (Freud, 1926, p. 166). This is the justification for proposing that annihilation fantasy anticipations be included in the basic danger series. (Hurvich, 1989, 2002, 2003a/b).

This is also true for experiences of being invaded, merged, disorganized, abandoned and destroyed. Thus, issues related to being overwhelmed or annihilated (Freud, 1923, p. 57) may be part of a traumatic moment in present time, or may characterize a danger situation that is anticipated in future time: concerns about being overwhelmed, etc., may thus reflect either present, actual, or potential threat (Hurvich, 2003a); Schur, 1953). This formulation is somewhat at odds with Kohut’s closely related concept of disintegration anxiety (Kohut, 1984), which he differentiates from the basic dangers.

To suggest an extension of the nature of the danger to include survival concerns constitutes a step in the direction of greater integration of the psychoanalytic theory of anxiety and the psychoanalytic theory
of psychic trauma. This rapprochement enhances and enriches both concepts, and renders them more relevant to the range of issues that arise in the consulting room, the psychiatric ward, and beyond. The annihilation dangers reflected in the six Dimensions enrich clinical understanding and expand the focus of anxieties that are seen as important and noteworthy. They constitute an attempt to further delineate the psychoanalytic formulation of anxiety, a concept Freud (1917) asserted to be central to the psychology of neurosis (i.e., of psychopathology).

An objection might be raised that putting traumatic-annihilation anxieties in the basic danger series blurs Freud’s valuable distinction between traumatic and signal anxieties. On the contrary, what is being underscored here is that traumatic anxiety and overwhelmed helplessness, i.e., the traumatic moment, can subsequently be anticipated, and associated with psychic content. And while in the traumatic moment, the anxiety response tends to be uncontrolled, when it is later anticipated, it may become associated with controlled affect. In this regard, it is useful to distinguish Annihilation Anxiety from Annihilation Content, the former usually implying uncontrolled anxiety, the latter, controlled. Annihilation content may thus be connected with a traumatic moment, but it may be the anticipation of a traumatic moment. As an anticipation, annihilation fantasies meet all the requirements Freud specified for a danger situation, as quoted above: a “recognized, remembered, expected situation of helplessness.”

Currently, there is a tendency to emphasize the essential similarity between traumatic and other anxieties (Brenner, 1986; Compton, 1980). But the substantial regression and disorganization that often accompany traumatic anxieties lead to outcomes that are consequentially different from those associated with non-traumatic anxieties. The difference is clinically meaningful. Defenses against traumatic anxieties include dissociative, catatonoid, paranoid and/or compensatory mechanisms [e.g., identification with the aggressor, abuse of alcohol and other drugs], and encapsulation (Hopper, 1991). Traumatic experiences may shatter fantasies of invulnerability and the person’s sense of safety in the world (Zetzel, 1949). When the anxiety signal is deranged or put out of action, the ability to anticipate psychic danger is compromised.
Indeed, Compton (1980) posited a negative correlation between helplessness and anticipation: “Roughly, the less anticipation, the more helplessness” (p. 755). These reactions are rarely found in non-traumatic anxiety responses.

4). A related contribution is the identification of annihilation anxieties as central to the more severe psychopathologies, in cases which extend beyond the neurotic range (Hurvich, 2002, 2003 a, 2004). These survival apprehensions are especially prevalent in more disturbed patients. They include psychoses, borderline and narcissistic personalities, perversions, many psychosomatic conditions, and many addictions. Full-blown annihilation anxieties are seen most dramatically in panic attacks, nightmares, acute suicidal crises and fulminating psychotic breakdowns.

The famous four basic dangers are also relevant for these more disturbed patients, but they tend in the latter often to be found in conjunction with, and to trigger annihilation apprehensions. Even here, additional distinctions can be made. For example, borderline and psychotic patients may deal with annihilation anxieties differently. Borderline children have been reported to retain awareness of threats of psychic fragmentation, while psychotics are more likely to mask such awareness with delusions (Frijling-Schreuder, 1969).

Additionally and consequentially, highlighting the centrality of annihilation anxieties in psychopathology beyond the neurotic range could lead to improvement of psychoanalytic psychotherapy with these more disturbed individuals by stimulating increased awareness in clinicians of the significance of these anxieties and their interrelationships. Awareness should also be raised regarding the relationship of AA to ego and super-ego functioning, particularly with character defenses as well as with defensive processes more generally, and with how they affect transference and especially countertransference reactions (Wallerstein, 1997).

5). Another contribution involves elaborating the meaning of annihilation anxieties in psychoanalytic theory by utilizing a propositional approach focused on specifying the essential features of
these anxieties (Hurvich & Freedman 2006; Freedman, Hurvich & Ward, 2007). The major components of this approach to psychoanalytic concepts are Coreness, Dimensions and Modifiers (Hurvich & Freedman, in Freedman et al, volume in preparation). This endeavor includes delineating the major assumptions and implications of the construct in succinct, declarative statements, cast in plain English language, that are potentially testable. It is proposed that any psychoanalytic concept can be clarified by applying such a propositional approach.

**Propositions Related to Annihilation Anxieties**

The following illustrate the Propositional Method in relation to the central topic of this chapter.

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

2. Annihilation concerns constitute early danger, but can be engendered throughout the life cycle whenever there is a perception-fantasy of survival threat.

3. Annihilation anxieties comprise a fifth basic danger, which interrelates with the four generally accepted basic dangers in various ways.

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

5. Excessive annihilation anxieties, especially during 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, pre-symbolic 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 by aggressive as well as by libidinal impulses associated with self and object representations are a repetitive finding in relation to annihilation anxieties.

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. (Hurvich, 2003a).

6). The last contribution involves a program of empirical research which focuses measurement of annihilation anxieties with objective and projective tests (see references already cited), and from the clinical interview. This material is not included in the current chapter.

**Six Annihilation Anxiety Dimensions and Sub-Dimensions**

The 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 six Dimensions are related to and sometimes overlap with Freud’s (1926) basic dangers (loss of the object, loss of love; of castration/bodily harm; and loss of super-ego approval (Freud, 1926), and may be triggered along with them, but also go beyond them. In their briefest designation, the annihilation Dimensions are:

1) **OVERWHELMED**

2) **MERGED**

4) **INVADED**

5) **ABANDONED**
A number of clinical observations are subsumed under each of these dimensions, such as apprehensions over disappearing, of leaking out, of being devoured or engulfed; of smothering, being trapped; of vertigo, of falling, fear of regression, of losing control of urges, and of going insane. Also included are fear of fear itself, as well as fright, terror, horror, and dread.

**OVERWHELMED**

1) BURIED ALIVE  
2) DROWNED  
3) FLOODED  
4) LOSS OF CONTROL  
5) OVERSTIMULATED  
6) SMOTHERED  
7) SWEPT AWAY  
8) TRAPPED  
9) INABILITY TO FUNCTION  

**MERGED**

1) ABSORBED  
2) DEVORED/SWALLOWED  
3) TRAPPED  

**FRAGMENTED: SELF/EGO**

1) SPLIT OFF  
2) DISAPPEARED  
3) DEHUMANIZED  
4) EVAPORATED  
5) FALLING APART  
6) GOING INSANE  
7) IMMOBILIZED  
8) MELTING  
9) MORTIFIED  
10) NEGATED  
11) NOTHINGNESS  
12) SHATTERED  

**INVADED**

1) BODY COMPLAINTS  
2) INTRUDED UPON  
3) PENETRATED  
4) PERSECUTED/TORTURED  

**ABANDONED**

1) CAST OUT  
2) CUT OFF  
3) DESERTED  
4) FALLING  
5) EXCLUDED  
6) REJECTED
1) KILLED  4) WORLD DESTRUCTION
2) POISONED  5) CATASTROPHIC MENTALITY
3) DEMORALIZED

While these psychic contents go a long way in defining annihilation anxieties, there is also a formal aspect, related to ego strength, that plays an important role in differentiating when “going to pieces” does or does not lead to “falling apart” (Epstein, 1998). These formal factors are set forth as variables in relation to traumatic (annihilation) and signal anxieties (Hurvich, 2004).

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<th>TRAUMATIC ANXIETY</th>
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<td>&lt;--------------------Assimilability of the Experience--------&gt;</td>
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<td>&lt;--Arousal of Previous Disturbing Memories &amp; Unconscious Fantasies--&gt;</td>
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While all of these add additional specificity to AA manifestations, the most central are Desymbolized/Symbolized (Freedman, Hurvich & Ward, 2007), Uncontrolled/Controlled (Hurvich, 1997; Schur, 1953), and Intolerable/Tolerable (Freud, 1894; Krystal, 1988).

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 and utilization of reflective functioning, etc.), there is a greater likelihood that it is an anticipation of a traumatic situation. The important issues of time of recovery and residuals, including the possibility of a traumatic neurosis or Post-Traumatic Stress Disorder are relevant here. Time of onset, whether infantile, childhood, adolescence or adulthood, is also a key variable. Severe childhood trauma tends to result in a permanent expectation and dread of a return of the traumatic state. In these cases, fear of emotions develops and thus increases the likelihood of an impairment of affect tolerance (Zetzel, 1949; Krystal, 1988). Under debate is the contribution of psychic trauma to pathogenesis more generally, and how to distinguish pathological influences of trauma from other pathological effects (Baranger et al, 1988). While his conception of psychic trauma changed as his theories evolved, Freud (1939) attributed a key role to psychic trauma in all symptom formation.

**Psychoanalytic Theorists Who Have Influenced My Views**

In the framework of this chapter, the current section must be substantially abbreviated. From Freud, most essentially was the two-fold view of traumatic and signal anxieties, and of the “traumatic moment”, the subjective sense of helplessness, the idea that anxiety is the first reaction to the trauma, and that danger situations develop hierarchically. From Anna Freud, (1952) there was the description of an early anxiety triggered by perceived threats to the intactness of the mental organization, a key basis for annihilation anxiety experiences. Max Schur’s (1953), emphasis on the distinction between controlled and
uncontrolled anxiety, with some nod to Freud’s distinction between bound and unbound energy; and between evaluation of the danger and the reaction to that evaluation: Silber (1989) additionally differentiated experiencing the danger, and its evaluation. Schur (1953) further focused on loss of the time sense due to regression in reality testing, resulting in earlier anxieties potentiating current ones; and eventuating in loss of the ability to restrict anxiety to a signal; and that resomatization is a regressive response to danger, which tends to reinforce the subject’s sense of actual danger, and often triggers secondary anxiety. I also learned from Krystal's (1968) early elaboration of massive psychic trauma, his identification of alexithymia as a key sequelae of psychic trauma, and his elaboration of Max Stern's depiction of the catatanoid response to trauma. Stern (1988) additionally defined the basis for signal anxiety as the ability to ascribe meaning to one’s states of tension, implying a degree of tension binding combined with subjective awareness.

Zetzel identified the issue of anxiety tolerance, and underscored the importance of experiencing some anxiety as a prophylaxis against future traumatic overwhelming. She also emphasized the place of aggression in the anxiety arena, as had Melanie Klein (1952) and Flescher (1955). Rangell (1955) made the important point that the psychic danger, in the sense of helplessness, leads to the fantasy-anticipation that things will get worse, never stop, and move toward total psychic and motor paralysis. Compton (1980) added the distinction between a danger situation and an anxiety response, and also recognized that anxiety experience is based on a fantasy of disaster, possibly a memory or repetition of an earlier state of helplessness, and that a time correction constituting the reality-testing component is needed. Compton further clarified that the components in the pathogenesis chain can occur in different temporal orders, but especially that perception of danger is what triggers anxiety, rather than the more popular view that anxiety signals danger. The perception of danger view comes from early Freud (1917), Stewart (1967), Waelder (1967), Schafer (1983), Gillette (1990), and Lazarus (1966). Additional Compton contributions I have utilized include his assertion (1980) that the traumatic state was always at the heart of Freud's anxiety
theory, which is the opposite of the view taken by Brenner (1953), who rejected Freud’s evidence for traumatic anxiety. I have found no challenge in the psychoanalytic literature to Brenner’s 1953 position, which suggests this key change of Freud’s anxiety theory has been insufficiently recognized. Brenner also decisively rejected the inclusion of psychic dangers beyond the famous four (1982, 1997). It has further been inadequately appreciated that Brenner’s widely embraced formulation of the calamities of childhood both collapses and confounds the distinction between a danger situation and a traumatic one, as did his 1953 definition of anxiety as "an emotion (affect) which the anticipation of danger evokes in the ego" (1953, p. 22). He claims this definition allows us to “avoid the unwelcome necessity of assuming that there are two kinds of anxiety” (p. 22) [emphasis added]. In contrast to this idea of “unwelcome necessity,” Freud’s presentation of the two sources of anxiety constitutes the essence of his revised anxiety theory of 1926, reiterated in 1933. In my view, Brenner’s more parsimonious formulation cuts out the heart of Freud’s 1926/33 revised theory, and virtually blocks further integration of the theories of anxiety and of psychic trauma, as already emphasized.

I have also learned from and utilized the insights of Winnicott, especially his “primitive agonies” (Going to pieces, Falling forever, Having no relationship to the body, and Having no orientation) (1962). Other influences include Laing’s (1959) Ontological Insecurities (Engulfment, Implosion/Impingement and Petrification/Depersonalization), and Margaret Little’s (1959) assertion that when annihilation anxiety prevails, everything is linked with survival and non-survival, and Bion’s (1952) evocative concept of nameless dread.

**CLINICAL APPLICATION SECTION**

The patient is a 56-year-old white, female, Christian-born college graduate with advanced degrees in her chosen field. She is from an affluent, non-East Coast family, with a financially successful father and an artistically talented mother, socially prominent community leaders involved in civic and religious activities; a power-couple, who projected a public image of the perfect family. The patient is the third of
four, with a brother five years older, one three-years-older (who died in 1970 when patient was 19), and a sister, six years younger. This is a selective case report included to illustrate the concepts delineated in earlier sections of this chapter.

**Presenting Complaints**

When we began seven years ago, the patient described herself as a “ball of pain”, with frequent anxiety and chronic feelings of dread, alarm that she was unraveling, and a pervasive sense of sadness, guilt and low self esteem. She was ashamed and discouraged over her weight. She had a tense and conflictual relationship with her parents. While socially popular, they showed little respect or empathy for others, and deeply resented being told anything about how they conducted themselves. Their façade of graciousness was underlain by manipulative and blame-avoidant trends. Domineering toward their children, the father had beaten them, especially the boys, and both parents used the silent treatment and ignoring when the children displeased them, up to the present day.

The patient also described an ongoing childhood disappointment and feeling of deprivation and rejection in the relationship with her mother, who “sucks all the air out of the room,” whose refrain was, “You are hateful and ungrateful,”—a mother whom she felt spoiled every day of her childhood. There was the quality of a narcissistic trauma, with the mother demanding attention and adulation but ignoring and devaluing the patient’s needs for consideration and recognition. The patient regularly felt depleted, unhappy, alone and exhausted. She did not feel loved for herself by her mother. A replay of this trauma has been central to the patient’s difficulties in her chosen profession, where she has been struggling to make something happen. Since age five, the patient had felt mother wanted to crush her self expression and wishes for attention. She also expressed concern that her boyfriend might kill himself, that she couldn’t bear his dependence on her, and that she did not know how to handle him.
As I later learned, for years the patient had an uncertain sense that something had happened with her father when she was little. She recalled no details, and the topic was off limits. Things were so terrible with her mother that she couldn't bring herself to question her relationship with her father and possibly risk losing him as well. She didn't have enough security with her sense of self to move in that direction. Reflecting back on that, she said, “As time went on, I developed a sense that you could help me with this, and then it took over three years of our hard work for it to fully come out. I had a vague sense that something was there, but allowing the rest of my mind to see the picture was slow in coming. There was guilt, fear of punishment, retaliation, and the dread of hurting my parents.” For years, she had felt ashamed, guilty and infuriated over how they treated her, and she was unable to deal with their overt and subtle criticism in ways that allowed her to experience good feelings about herself.

The patient acknowledged great difficulty entering intimate relationships with men, stating that when a man showed interest in her, she felt cornered, and when she yielded to him, it felt like she was “in free-fall, like falling off a cliff.” “Sex ruined things,” she said. And it was only with her current boyfriend of 20 years that sex was eventually successful, but they had not been sexually active for the past five years due to mutual agreement, and more recently due mostly to his disinclination. Reports of childhood sleepwalking and, during her early 20’s, awakening in the beds of men she hardly knew and not remembering how she got there, pointed to dissociation and a likely history of sexual abuse. As the analysis proceeded, repetitive psychic trauma from childhood sexual relations with the father came to be recognized as a significant psychic organizer.

Course Of Treatment

This on-the-couch psychoanalytic treatment began at 2x a week, and later increased to 3. The patient's dreams and fantasies have been dominated by sexual and aggressive imagery. She's had many fantasies of hurting her father painfully and severely, without clearly understanding why, until the reasons surfaced during the analysis.
**Dead Girls in the Closet Dream**

The first dream, reported after four months was one she’d dreamt at age 35 while in a previous therapy. This earlier treatment had been sought following her being sexually seduced by a Swami, as reported below. : “There’s an empty house, and I’m desperately looking to save someone. I’m going from room to room, opening closets, and in every one I find a dead girl. It looked more like a Halloween skeleton, but I knew it was a dead girl.” She associates the dream setting to her female cousin’s bedroom where, as an adolescent, she thought she saw the girl’s father fondling her breasts, and the cousin looked unhappy.

In exploring the dream, the patient associated herself to the dead girls in the closets she was trying to save,. The Halloween skeletons “are supposed to be scary, but they aren’t real. Still, in the dream, it was really scary.” This decades old dream, remembered in the treatment, hinted at incest via the uncle. I pointed out that, in the dream, she discovered that something had killed her long ago, perhaps psychically, and that skeletons in the closet, suggested hidden family secrets. I noted that she had strong motivation to rescue herself and that, while she felt very afraid, she attempted to deny the scariness” [via the Halloween skeletons].

In the earlier therapy the patient had been unable to say the dead girls dream aloud, and the therapist then asked her to write it down, while commenting that she thought the patient was being melodramatic. She dates the high level of anxiety she had suffered for years to the dead girls in the closet dream. The patient told me that the secret was ready to come out then, but the therapist did not know how to handle it or help her bring it out. As a result, it “left me with twenty years of anxiety before we got to it here.”

A few sessions later she described another dream of having gone to the bathroom, where she pulled out a tampon, and tampons kept coming out. Her association was to secrets. The dream imagery suggests the secrets relate to extruding things from her genitals. After reporting this dream, she recounted a long forgotten memory of how, while baby-sitting at age 12, in a semi-trance-like state, she had sexually
stimulated a four-year-old boy while he slept. This is an example of the obligatory repetition found in many trauma victims; the urge/tendency actively to perpetrate what had been passively suffered.

Once the patient recovered this memory, following the report of the dead girls in the closet dream, she postponed, for three weeks, telling me of a freshly remembered episode from when she was thirty. At that time she had been seduced by a Swami from an Eastern spiritual community to which she had become attached. She lost her will when the Swami unexpectedly made physical advances. Following the report of the event, she described sensations that the floor was coming out from under her. She was unable to stop crying, felt like killing herself, and had to sever her ties with the group. For months she felt mystified at her state of mind, gained weight rapidly, and sought therapy. She recalls being so pent up and frightened at the time, that on her way to the early sessions she rolled up her car windows and screamed to release the virtually unbearable tension.

Remembrance of the Swami molestation, following the recovery of the episode where she had fondled the four-year-old boy, led to a gradual awareness, described by her as a series of snap-shots that slowly became a more continuous memory, which led to the connection that her father and she had long engaged in sexual activity, between ages four and twelve. As she said, “The idea that father had a deeper connection with me that I hadn’t remembered was cracked open. What I did to the little boy, and what had happened with the Swami felt real, and opened the memory that father had done things to me, and that they were real also.” Here the recall of what she had actively perpetrated—turning passive into active—preceded and likely expedited uncovering of the father-incest memories, as did the recall of being passively seduced by the Swami.

An additional, recent event also seemed related and facilitative: the patient had successfully headed off a habitual fault-finding/blaming ritual to which the parents regularly subjected her when they visited New York. We came to see this as a pattern: other therapeutic breakthroughs, especially recovery of memories and the making of significant connections, followed experiences of active mastery in her
current life. Here is an example of the working through of the traumatic memories, repeated many times with related imagery and different details; and here again, including active fantasy responses, alternating with the accompanying annihilation anxiety: “I’m his little girl [crying] and if he realized and thought of that, he wouldn’t have done all these things. Now I’m switching it around, because I used to be afraid he was stabbing me and splitting me through the middle. Now, I want to put my fist through his throat and split him all down the middle, and then, bleeding and split open, I want to walk on him. She continued: “Remembering being close to him, I feel like I’m falling off a cliff, falling into nothingness. (What emotion?) I’m terrified, diving, running away. My mind goes, like over the cliff, so I won’t be there…. (More detail?) I’m lying down, and I can’t get away, flat on the bed, and the only thing that can get away is my mind [dissociative defense]. So diving off a cliff allows me to get away. It becomes a happy escape, like jumping into a lake from a rope tied to a tree branch, like I did with my brothers at grandpa’s farm.”

The Carnival Dream

Several years into the treatment, as she was recovering some disconnected fragments of the incest episodes, the patient reported the following dream. The sexual explicitness stands in marked contrast to the more disguised imagery of the earlier dead girls dream, and is consistent with the view that dreams with such content suggest efforts to master childhood traumatic experience (Fine, Joseph, & Waldhorn, H .F., 1969) Here is the dream as she reported it: “A bedroom turned into a children’s carnival. There were three women there with no clothes on, but they were wearing make-up. I’m an adult and am told to sit on the edge of the bed and spread my legs. I said, ‘I’ve never done this before.’ The most grotesque woman starts stimulating me with her tongue, it’s bizarre. I allow it but I am not enjoying it. She looks up at me and says, ‘I’m a virgin giving head.’ I thought, ‘Now I’ve been to whore’s camp.’ There’s a hula-hoop and I am supposed to throw a plate through it into a basket. People come into the room, shine a spotlight on me, and someone says, ‘It’s M’s (the patient’s) turn.’ Another says, ‘No, she already had a turn.’ I get a plate as a prize and I recognize it as Aunt B’s plate “ [the mother of the girl whose room was
associated to the dead girls in the closets dream.] The patient now reveals that the cousin’s father had chronically abused the cousin sexually. It’s the cousin she had seen being fondled by the girl’s father, as reported earlier. “The grotesque woman’s tongue was very specific, a strong sensory feeling. I’ve never seen a tongue like that! Thick, and too red, and too big for her mouth. I watched her go back and forth over the inside of my legs—it felt real, like I’d experienced that before. The feeling, it was all grotesque and wrong, but I was supposed to be polite, not say anything or protest. In the dream it seemed like a routine thing, like the dead girls in the closet.”

**Carnival Dream Associations**

“The faces of the naked women running the carnival were distorted because of their sexual arousal, and reminded me of an X-rated Fellini film. [Such distorted facial expressions were later connected to her father’s unfamiliar look when he was sexually aroused]. They asked me to throw another plate, and my father yells, ‘No, she’s already misfired.’ (Misfired?) It’s the man that misfires. (What occurs to you ?) “An explosion, like a bomb going off in my face, from the ejaculation, too close to my face.” This traumatic memory surfaces as an association to the dream. These are the kinds of traumatic memories recovered in the analysis. Others were of father drying her off after her bath, of his face and body being very close to her, and of feelings of excitement, vulnerability, disorientation and dread.

Several sessions after telling the carnival dream, the patient revealed for the first time that she had followed stimulation of the little boy with pleasuring herself, and believes the incident took place when she was around twelve, the time she earlier reported that the incest activity stopped. The incident had been unrecalled for years, but its meaning, together with the recovery of the Swami experience, were instrumental in facilitating the gradual recapture of the incest memories. The comment about pleasuring herself provided an “in context” opportunity to ask about her masturbation fantasies.
Masturbation Fantasies

Masturbation fantasies regularly provide clues to the person’s preferred conditions for sexual pleasure and indications of object-relational dispositions, the ideal adult version being an integration of sex and object love. This patient’s masturbation fantasies have been strongly influenced by her sexual traumata and the meanings those had for her, and are a clear example of how the sexual traumas constituted psychic organizers. The two repetitive scenarios she told me were: “When I touch myself, I imagine I am working in a brothel, but I’m behind a board—I give the men sex but they can only see the bottom half of me…..” [A second fantasy:] “I’m in a large room, sitting on a sacrificial table, waiting for the king, and the whole town is watching, and trying to get me excited by their presence. The king comes in, has sex with me, but I win, because I do not get excited. He loses control of himself, and I do not. I’m the one in the center of things, and I am in control. Here it’s not secret, it’s public. I receive great public acclaim because I’m the winner.”

The patient later added another basis for the resistance to getting excited, and connected it with childhood headaches she chronically suffered. “I resisted the pleasure I now seek because it was related to something that was morally WRONG.” The deliberate pleasure inhibition subsequently resulted in her losing control of the excitement, and, for some years, she had not been able to get excited over sex with her boyfriend. That seems now to be changing.

In both masturbation fantasies, she is a victim: in the first, a prostitute in a brothel who provides sex but limits her participation to her bottom half—it is sex without loving or being loved by the partner, while she hides and withholds herself. The second fantasy involves submission to being sacrificed to the sexual desires of the king (father), but here she turns the tables, “stoops to conquer,” as she appears to submit to being sacrificed, and triumphs by resisting successfully the sexual excitement, in contrast to the man/father—who “loses” because he cannot control his sexual desires. In these prototypical fantasies, constructed to enhance her sexual arousal, the patient describes sexual dynamics centering on the issue of
control over sexual abandon, i.e., in sado-masochistic terms, rather than in terms of mutuality. It is a kind of obligatory fixation in a person who has been chronically sexually seduced and betrayed by her father, and, later, by other men, with her unconscious compliance. Also worth noting is the series of reversals in this fantasy: it is public, not private, and she gets community praise for not giving in to the sexual excitement. She was able to recall that she was terrified that the secret might become known by family members, while, at the same time, she had had a strong urge to reveal it.

While the direct traumatic impact of the sexual violation has been demonstrated, another sequela of the incest was the way in which identity integration was impeded. The patient came to realize, in the course of the treatment, that she could not bring together the image of herself as an ordinary girl and the image of herself as her father’s sexual partner. Further, she had a parallel difficulty with achieving an integrated mental image of her father: she could not bring together memories of him in the family situation of her day-to-day life with memories of his unfamiliar visage in the now partly-remembered sexual situation, which she currently recalls as having been distorted, vacant, and unrelated to her. Another indication of compromised self-integration were her split-off partial self-representations described below.

Facilitative External Events

The analytic work was aided, complemented and potentiated in the fifth year of the analysis, when the patient’s niece, while psychiatrically hospitalized for suicidal ideation and for a serious eating disorder, accused her grandfather (the patient’s father) of having molested her repeatedly. When the patient’s sister, the girl’s mother, expressed serious doubts concerning her daughter’s accusation, my patient then revealed to the niece’s therapist that she herself had been molested years earlier by her father. This account was leaked by the therapist to the niece’s father, who confronted the patient’s parents. The patient’s father stated that since his daughter and granddaughter had made these accusations they must be true, but that
he remembered nothing. He apologized to both, went into personal therapy, and made what the patient initially thought were efforts at reparation.

The effect of getting the secret out, the subsequent support the patient received within the family, and the details of her parents’ responses as the situation unfolded, were followed in the months ahead by a substantial lessening of the patient’s intense shame and guilt. This clinically significant series of events was represented in a subsequent dream reported during this period in the treatment.

“I am in a clean, light apartment, and notice a vile, black, mold-like substance leaking out of the wall at the baseboard. The super says that if we remove the outer wall layers, the mold will be detoxified when it is exposed to the light and to the air.”

An additional facilitative factor was the realization, as a result of reading an article in The New Yorker on psychopathy, that her father had psychopathic traits. This led to her understanding better why his cold behavior and changed appearance during the sexual encounters threw her into such a frightened state of mind. It clarified that he wanted a physical intimacy that did not signify his love for her. This, for the patient, constituted a rejection that paralleled her mother’s ongoing rebuff. In addition to the directly traumatic aspects of the paternal sexual behavior, the patient, as already mentioned, experienced this intimate liaison as a compensation for the lack of being made to feel special and loved by her mother. It was when the patient realized that her father otherwise treated her in no special way, that his manner was devoid of tenderness, that he was satisfying himself without regard for the consequences to her, and that his remembered facial expression was blank and unloving, that it all changed into a traumatic betrayal, a second trauma on top of the first."It was my recognition of being used that hurt the most”.

The patient’s mother went into a depression following the incestual news, and made a serious suicidal attempt. The patient’s father subsequently sustained several physical injuries from accidents. Now, less afraid of her father and less intimidated by her mother, she was more able to believe that what had happened was not her fault. She began to recognize that she had in fact not hurt others the way she
believed/fantasied she had. She does still feel guilty about stimulating the boy, however, and appreciated my comment that she very likely did not do him any lasting harm.

The deeper level of these issues was being simultaneously pursued in the analysis. The patient had described a painful repetitive fantasy while growing up of being trapped in a box-like room where she bounced from one wall to the other, feeling like she was spinning out of control. This was associated with a feeling of confusion that was followed by an anticipatory dread of disintegration. We were able to put these experiences together with her difficulty in integrating disparate images of herself and of her father as follows: both the bouncing sensation and the dread were related to the virtually intolerable disjunctive conflict created by a detail of the incest. At night the patient would lie in bed with a combination of sexual excitement and dread that her father might come in. The excitement was both of the anticipated exquisite bodily sensations, as well as of the implications of the oedipal victory over the rejecting mother. It was the confusion in her mind created by this conflict that threatened to drive her mad. Also of central importance was the conviction that it was all her fault. This was found to be based on the undeniably thrilling sensations that suffused her body during the actual incest Recovery of the memory of the molestation of the boy, and the Swami seduction both strengthened her awareness that the incest was truly initiated and controlled by her father and not by her, as she had feared.

The recent revelations in the family that he had incested his granddaughter, and his subsequent attempts at some apparent repair, in conjunction with her even more recent realization that her father had psychopathic traits, further strengthened her belief that she was not the guilty one in the secret childhood liaison. Her feelings of specialness and superiority over her mother, and the idea that she was winning were additional factors making it difficult for her to overcome the belief that it was all her fault.

As we worked through these issues, the patient demonstrated significant improvements in professional and personal achievements, together with noteworthy increases in self-esteem and a greater subjective tranquility. “I’m in a new phase: more ease, more fun, more discipline and less pressure from
within. I enjoy the little things much more”. Of special note is the decrease in experiences of being overwhelmed, and the concomitant increase in reflective functioning, allowing her to anticipate that she was now capable of handling situations that had previously immobilized her and filled her with intolerable and disorganizing anxiety, guilt and shame. Just prior to my sending this chapter to the editors, the patient stated that she had reached a “critical mass of feeling safer, and that her pulse rate is substantially lower than it has been for twenty years.

Patients so burdened with chronic anxiety, guilt and shame typically do not show the extent of therapeutic improvement demonstrated by this patient, particularly without psychotropic medication. Despite the long-standing dominance of these dysphoric affect states, she displayed good academic functioning and high professional achievement, indicating that a number of autonomous ego functions had not been substantially compromised. The patient’s description of herself as a child who was a spirited playmate is suggestive of good psychic hardiness. Moreover, a grade-school teacher had told her mother that the patient was a natural leader.

From early years, the patient’s maternal grandfather was a particularly beloved person. There were many memories of happy childhood weekends and summers spent on her grandparents’ farm. Many happy experiences with her older brothers were also fondly remembered. Growing up she tagged along with them, and they protected and supported her. She had a deep and satisfying relationship with her brother D who died when she was nineteen. The patient claimed that losing him led to her to “waking up to what was really important in life”. It is likely that these relationships and experiences added to her potential trust, and positive internalizations, and were additional contributing factors that played some role in the substantial improvement she has been able to achieve.

More directly relevant to her capacity for improvement were the facts that she did not meet diagnostic criteria for borderline personality, and demonstrated a number of ego strengths, including impulse control, anxiety tolerance, and sublimatory capacities. She has not been a difficult patient in the
sense that the analyst did not experience psychically painful (extraordinary) counter-transference (Freedman & Lasky, unpublished) reactions with her. She has not brought disruptive and controlling projective identifications into the interaction, and has not shown generalized aggression infused, split-off introjects. The analysis is ongoing, and the substantial success of the work and increase in the patient’s self esteem and bolstered ego strength enhance the possibility of exploring the darker residue from the past more fully, that could potentially lead to a swing into the transference, and potentially become a disruptive factor in the counter-transference.

Thus far, this patient has not challenged the frame, and once she came to feel and believe the therapeutic space was safe, she participated in a successful therapeutic alliance. That is, she consistently attempts to say what is on her mind, listens to what she herself says, listens to the analyst’s comments and questions, and reflects on and attempts to integrate both.

RELATION OF THIS ABBREVIATED CASE SUMMARY TO ANNIHILATION ANXIETIES

The case description includes many examples of annihilation anxieties that reflect typical forms of anxiety experienced and reported by this patient. She summarized the dilemma of her childhood as “feeling overwhelmed and trapped with no place to go, like running into a wall, trying to escape and realizing there was no exit. And the frightening part was that it didn’t stop.” Central to feeling trapped was the secret about the sexual experience, which she could share with no one out of fear that it would destroy the family and eventuate in her mother killing her. When the father incest was remembered, a further strand of guilt emerged, the idea that she had injured him physically. The evidence for this was her memory that, following his ejaculation, her father’s penis became limp and smaller, i.e., injured. The wish to harm his penis had come into the analysis prior to her remembering the incest, and she reported a substantial initial increase in her guilt feelings as memories of the sexual details progressively emerged.
With regard to her mother, the patient felt she would never get the love and recognition that she needed. The patient's material revealed examples of each of Freud's (1926) famous four dangers: loss of the object, loss of love, genital harm and superego reproach, as well as most of the six annihilation dimensions described earlier. The details of the patient's material demonstrate how her experience of the four dangers regularly triggered annihilation concerns. Thus, the patient's experience of the mother's emotional abandonment and withholding of love goes beyond Freud's description of loss of the object and of love, and triggers feelings of disappearing and of nothingness. In addition, her concerns over genital harm also were infused with annihilation implications: “I felt the genital penetration as a burning sensation that was like an infected shot. Like father had infected and poisoned me.” And lastly, the superego reproach, which had to do with her feelings of guilt and the assumption of responsibility for the incest, resulted in her feeling blocked and overwhelmed, lest she reveal the terrible secret which would lead to the destruction of the family and her own death/retribution by the mother, as already mentioned.

Regarding the traumatic memory of being dried off by her father after her bath, the patient described an experience of watching what was happening from the ceiling, like it was happening to someone else. This dissociative defense is frequently found in situations experienced as traumatic, and that involve annihilation anxieties.

Other dissociative phenomena were reflected in the presence of three “part-selves” about which the patient became aware beginning at ages 5-7, following the initiation of the sexual episodes. She described herself as being divided into the Fetus, the Witness, and the Monster Girl/Lollie Hothead. She experienced these three part-selves as helping her throughout her childhood and continued to be part of her experience of herself as split. “They made me feel safe; my secret protectors, my allies.”

The patient described the fetus as “so large it was blocking my path toward going forward, to going anywhere. It was a needy, infantile part of me. The Witness girl kept control for me, locked everything away, stayed quiet. She was like a parent, helping me by telling me the right thing to do. Lollie was very
bad. But she’s fun, and hope—she’s me, the secret me. Then, I felt like I didn’t have a together self”. (What was that experience like?) “Just getting by. It was so much work. I never really felt satisfied. I was never really together; had only a vague idea of who I was. Instead there was extreme tension in my emotional life, and I felt very cut-off from my mother. I’m coming to see how all this was modeled on my relationship with mother in an important way. It was a daily sense of pain with her.” (In these frustrating, ongoing experiences with mother, and the secret stuff with father, the girls helped you get by—even though the price of them helping you was that they contributed to your not feeling together. What is your sense of self like now?) “Now the basic experience of relating to another person has changed. Before I met you I was holding on, but any pressure made things feel very chaotic—too much to deal with. That’s how it was with my earlier therapist. Somehow here it’s been different. I have built up a sense of self working with you. By pushing the girls away I have space. When we were all together it was too noisy, too much trouble. It was like I was in a bunker and there was no room for them, and the time came when I didn’t need them anymore, so I cast them out.”

These part-selves were experienced by the patient as contributing to her sense of power and agency when she sorely needed it; they served as a foil against the massive experiences of helplessness, terror and entrapment. So they were more like imaginary companion/part selves than the inner saboteurs of Fairbairn, and are more indicative of ego strength than ego weakness, more suggestive of adaptive than maladaptive defense. Feelings of being Overwhelmed, Trapped, Disorganized, and Destroyed were an integral part of the patient’s therapeutic narrative.

The presenting symptoms described earlier—such as chronic dread and fear, intense shame, severe narcissistic trauma by the mother, chronic sexual invasion by the father, pervasive guilt feelings, and the presence of dissociated part-selves—are regularly found in conjunction with annihilation anxieties. Focusing on and exploring manifestations and close derivatives of annihilation anxieties was therapeutically useful in getting to the key underlying fantasies and in working through the specific anxieties involved. The
patient acknowledged the value of these ways of describing some of her experiences: “When I feel someone is controlling me, it can lead to feelings of losing myself, I get lost. (More?) I don’t count. I’m forgotten. I feel that I’m not even here. I disappear and it’s very frightening.” We thus came to see how these intolerable feelings led to dissociation, including the feeling that she could disappear. In addition to the helplessness, she experienced the disappearing as her revenge, and this calmed her anger. “If I’m not here then it can’t happen” [i.e., further sexual assault].

The earlier-described sensation of falling off a cliff into nothingness, following memories of the incest trauma, illustrates the proposition that annihilation anxieties constitute trauma markers. The falling sensation morphs into a dissociative escape defense from the incestuous memories, and then there is a recruitment of positive memories of playing with her brothers at her grandfather’s farm. In the working through, the patient came to see the recalling of the dead girls dream, molesting the boy, the memory of the Swami seduction, and, later, the carnival dream, as key stepping stones to uncovering and elucidating the traumatic history.

**Transference Aspects**

The earliest transference theme related to questions of safety and trust. That is, whether I needed her to satisfy me (as each of her parents had, in their own way), or whether I could help her without “needing her”. The first underlying, specific concern was whether I could respond to her need to be understood as she was, without requiring, as her mother had, that she meet my needs for recognition and affirmation. The other particular concern, after the memories of her sexual relationship with her father had surfaced, was whether I would require from her the sexual surrender insisted upon by him. Her own vulnerability in this regard was underscored by her experience with the Swami’s sexual advances. When he approached her, she was shocked, but quickly reverted to a passive mode, and silently acquiesced to his
requests. For her entire adult life she had felt threatened when confronted with seductive behaviors by men.

In the therapeutic situation I was able to establish a friendly but professional tone, which allowed the patient to experience me as physically non-threatening. A remaining concern was that she would lose control of herself, as she had with the little boy reported earlier.

The early hours were filled with concerns over the boyfriend’s mental condition. She later revealed that my helping her understand his behavior increased her hope that I could help her understand herself. My ongoing interest in the unfolding story about her childhood unhappiness with her mother’s exploitive way of relating to her, together with the so far unclarified strong negative feelings and fantasies toward her father gradually led to feelings of safety in the room, and a burgeoning belief that she could explore with me the mystery of what might have happened with her father when she was a child. Her conscious involvement with the details of the mother mistreatment likely had served as a trauma screen against remembering the father incest.

The patient’s greatest fear in the transference was that I would cast her out. The various fantasied reasons were because she wasn’t improving fast enough, that I didn’t like her, that she looked attractive, or didn’t look attractive enough. She additionally feared I would send her away if she were playful, or even worse, if she were flirtatious. I decided not to pick up on any signs of flirtatiousness or sexual innuendos, a stance regularly taken by many psychotherapists with victims of childhood (and former-analyst) sexual abuse. Her fear that I would cast her out played a role in the patient making an effort to control any such tendencies. I believe it will be possible to analyze this issue later in the analysis. The key genetic (historical) connection with the fear of being cast out was that she wanted to cast out her father, because of his sexual conduct. She also expressed fear that I would become envious or disapproving of her accomplishments outside therapy, that I would become tired of her complaining, or that I would move away, or die. One
instance of fearing she had disappointed me was followed by a fantasy of the two of us hugging, kissing and making love.

From the time of the dead girls dream, the material unfolded in fits and starts, but progressively. I regularly summarized the patient’s associations and memories, our cumulative understanding of the dynamic and historical picture and pointed out gaps in the evolving story, taking care not to get ahead of her with speculations concerning what might have transpired. While these are routine analytic functions, I saw them as especially important in a patient with the degree of dissociation in the history, and who was sensitive to sexual seduction, as pointed out. Recently, the patient stated: “The space you have created here has helped me to define myself and to grow stronger.”

When I asked her permission to use material from her analysis in a professional publication, she agreed after thinking about it, and stated that one reasons she thought I had “chosen” her was because of the progress she had made, but denied any further thoughts about it. Since a major complaint against the parents was that they had used her for their own purposes, the patient may subsequently take up further feelings about my request and her agreement.

In closing, I would like to make two additional points. The first is, my impression from reading the literature is that many analysts deal with descriptions of being overwhelmed, trapped etc., as some kind of end-point or bedrock, and do not pursue such issues further. In this chapter I have illustrated the clinical value of recognizing annihilation anxiety dimensions and working with them. The second point is to include the reactions of the patient presented here to my highlighting her relevant experiences in terms of annihilation anxiety Dimensions and sub-dimensions.

‘Today, you brought to my attention that what I had been talking about reflected a sense of being trapped. That way of putting it made it more real to me and focused more specifically the basic issue. It led to an aha! feeling. Your use of that term and, earlier, the terms ‘overwhelmed’ and ‘invaded,’ and later your repeating the words ‘overwhelmed’, ‘invaded’ and ‘trapped’ that I had used, made me feel really
understood, like bells were going off, like you really got my meaning. If you said it was difficult, or something general like that, I don’t think it would have had the same effect. When you said, “it’s like you are trapped,” triggered an emotional response. It’s like it organized the feeling, and I felt a connection, and that I was not alone with a unique experience.”

The evocative quality of these annihilation terms is likely based on the fact that they were included as dimensions and sub-dimensions due to their having turned up in the psychoanalytic literature repeatedly. They reflect clinical generalizations and clinical observations that have surplus meaning, which is often related to survival concerns. Rather than treating such terms as end points, which halts psychoanalytic exploration and inquiry, these terms can constitute a jumping-off point, an opening of the window to deeper reaches of the mind. This patient further associated to “trapped” a feeling of being cornered, controlled and unable to move. At another time, feeling trapped evoked an image of falling into the abyss.

The mutative importance of the transference was reflected in the patient’s linking of the analyst’s way of working and his choice of words with her capacity to organize her thoughts and feelings. We have similarly found in the therapy sessions of a torture victim (Freedman, Hurvich, & Ward, 2009) a significant correlation between the relative quality and intensity of the transference and meaningful changes in the patient’s annihilation dimensions. This suggests a potentially central role played by transference in treating patients suffering from annihilation anxieties. In this sense, the manifestations of annihilation anxieties can be seen as a component in the psychoanalytic/psychotherapeutic clinical process.
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