Open Access Journal of Behavioural Science & Psychology
ISSN: 2642-0856

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Review Article *Volume 7 Issue 2*

Covid-19: Wakeup Call or PTSD?

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Received Date: November 01, 2024; **Published Date:** November 15, 2024

Abstract

The outcomes of trauma have been described by Breuer, Janet, Dorahy, van der Hart, Nijenhuis, Kathy Steele, Buler, Crabtree, Brown, and van der Kolk, among others. The COVID-19 pandemic is a major traumatic event. Will it result in mass PTSD (Post-traumatic Stress Disorder)? Or will we dissociate the events and return to normal the minute an efficacious vaccine or a cure is found?

Keywords: Covid-19; Depression; PTSD

Abbreviations

PTSD: Post-traumatic Stress Disorder; SD: Structural Dissociation; OSDD-1: Other Specified Dissociative Disorder subtype 1; DESNOS: Disorders of Extreme Stress Not Otherwise Specified.

Introduction

We can consider the aftershocks of the pandemic by using several models:

The Kubler-Ross Cycle of Grief

Denial, Anger, Bargaining, Depression, Acceptance.

Narcissistic Mortification

Narcissistic mortification is "intense fear associated with narcissistic injury and humiliation ... the shocking reaction when individuals face the discrepancy between an endorsed or ideal view of the self and a drastically contrasting realization". Rothstein A [1]: "... fear of falling short of ideals with the loss of perfection and accompanying humiliation". This fear extends to intimacy in interpersonal relationships (Fiscalini), unrealized or forbidden wishes and related defenses [2], so aptly summarized it: "fear associated with rejection, isolation, and loss of contact with reality, and loss of admiration, equilibrium, and important objects." Kernberg O [3] augmented this list by adding: "fear of dependency and destroying the relationship with the analyst, fear of retaliation, of one's own aggression and destructiveness, and fear of death." Narcissistic mortification is, therefore, a sudden sense of defeat and loss of control over internal or external objects or realities, caused by an aggressing person or a compulsive trait or behavior. It produces disorientation, terror (distinct from anticipatory fear), and a "damming up of narcissistic (ego-) libido or destrudo (mortido) is created" [2]. The entire personality is overwhelmed by impotent ineluctability and a lack of alternatives (inability to force objects to conform or to rely on their goodwill). Mortification reflects the activity of infantile strategies of coping with frustration or repression (such as grandiosity) and their attendant psychological defense mechanisms (for example, splitting, denial, or magical thinking).

The pandemic of COVID-19 hit everyone simultaneously as a universal, inescapable external shock. Several elements in the progression of the pandemic rendered it traumatic:

- The exponential inexorable contagion which fosters a feeling of impending doom (extreme stressor);
- The extreme uncertainty regarding every facet of the disease - from the pathogen to the nature of the illness through to the long-term social and interpersonal effects of the desperate and ever-escalating attempts to rein it in. This led to rising rates of anxiety, depressive helplessness, hopelessness, and disorientation [4];
- A lack of clear horizon and timeline which engender a sense of alarming insecurity;
- Mortal fear of disability and death;
- The transformation of the familiar - including one's body, nearest and dearest, habits, and familiar landmarks – into alien, minacious, estranged entities to be avoided on pain of life, as a condition for survival;
- The breakdown or incapacitation of all support networks, human and nonhuman (technologies).

The COVID-19 pandemic is a major traumatic event. Will it result in mass PTSD (Post-traumatic Stress Disorder)? Or will we dissociate the events and return to normal the minute an efficacious vaccine or a cure is found? In countries which succeeded to control the outbreak, indications are that people are not experiencing PTSD - but rather develop traumatic dissociation, which gives rise to anxiety and depression [5].

I suggest that there are homogenizing effects worldwide mediated via social media, the mass media, and identical measures introduced by political and medical authorities in every corner of the globe. This homogenization led to collective trauma and the formation of a collective ANP and EP, replete with dissociative symptoms.

Traumatic Dissociation

Freud S [6] that individuals with alleged trauma memories go through numbing, detachment, amnesia, and avoidance of triggers and memories - and being triggered [6]. Trauma was the main topic of study of early psychoanalysis (until Freud recanted with false memories even regarding his own father.) Different structures of personality experience too much or too little.

Structural Dissociation

Dissociation: integrative deficit, not defense (child has few active defenses). Its symptoms are both psychoform and somatoform. Integration and adaptive behavior depend on synthesis (association of all components of experiences and functions into meaningful coherent mental structures both episodically and across time) and realization (analysis and assimilation via personification and presentification - bring past and future to bear on present, mindfulness and reflexivity). Depersonalization is failure in personification (semantic not episodic memory). Trauma reduces integrative capacity. In premorbid personalities with low integrative capacity, it may lead to dissociation.

Post-traumatic dissociation is distinct from dissociative processes (mere integration failure) and normal dissociation (when you listen to this presentation, for example) [7]. Skeptics counter that dissociation produces fantasies of trauma, and that DD are artefactual conditions produced by iatrogenesis and/or socio-cultural factors. Almost no research or clinical data support this view.

Historical Idea of Dissociation

Dissociation results in "two or more systems of ideas and functions that constitute personality". The outcome of the inability to integrate owing to physical illness, exhaustion, stressors, or young age. Dissociation leads to pathological alterations in consciousness, greater emotivity, and reactive behaviors and beliefs [8-11]. "Each of these psychobiological systems has its own unique combination of perception, cognition, affect, and behavior; each has its own sense of self, no matter how rudimentary" APA 2000: dissociation is the "breakdown or disruption in usually integrated functioning"

Action Systems and Parts: Useful Metaphors in a Model

We must carefully distinguish between structural dissociation (dissociated self-states or "personalities" up to DID or tertiary SD), dissociative phenomena, and non-dissociated self-states or personality states (atypical DID states, rejected by SD theory as "reification").

Action systems (inborn, self-organizing, self-stabilizing, and homeostatic emotional operating systems):

- Guides daily living and survival of the species (AS1)
- Physical defense under threat (AS2 comprised of the 4 Fs: flight, fight, freeze, fawn)

Action systems 1+2 = social defense against abandonment and rejection (goes haywire in BPD) and interoreceptive defense against mental content (=defense mechanisms, primitive like splitting or sophisticated like passive-aggression). Charles Samuel Myers (1940) observed, in acutely traumatized war veterans, that AS1 is linked to ANP (apparently normal parts) and AS2 is linked to EP (emotional parts of the personality). Myers called them "personalities", but today we call them "parts".

EP contains vivid trauma recall (flashbacks) and vehement negative emotionality (fear, horror, helplessness, anger,

guilt, shame). But it could also manifest as listless, non-responsive, submissive behavior - or as derealized and depersonalized dissociation. They are all commonly linked to body dysmorphia and a sense of a separate self. Laufer called EP "war self", Wang "survivor mode" [12], Tauber child part of Holocaust survivor compound personality, "zombie parts" in trauma-related BPD [13], alters in DID, or identities associated with situationally accessible trauma-related memories, abuser rage, victim rage, passivity. ANP represses traumatic memories and avoids triggers via amnesia, sensory anesthesia, restricted emotions, numbness, and depersonalization. ANPs are Laufer's "adaptive self", Wang "normal personality functioning mode", Tauber's adult part, Golynkina's "coping part" in BPD, host personality in DID, or identities associated with verbally accessible memories of general autobiographical experience and of some elements of traumatic events (no one can accuse Brewin of being catchy) [14].

EP interferes with ANP and because it is a container for trauma-related memories and overwhelming and disorganizing emotions (many "empaths" confuse this defenseless skinlessness with empathy), these intrusions lead to impulsive, defiant, and reckless maladaptive reactance. ANP is conditioned to fear the EP and reacts to intrusion by altering or lowering consciousness, substance abuse, addictions, compulsions, self-mutilation (to silence the inner voice of the EP) [15,16], phobias of mental action, of the dissociative parts, of attachment and intimacy, of attachment loss, of normal life and change. There are also processes of evaluative conditioning: associating neutral stimuli with negative or positive outcomes and feelings owing to prior association with negative or positive stimuli), diversion, and estrangement. Individual can have one of each ANP and EP (Primary SD), one ANP and two or more EP (Secondary), or multiple ANP and EP (Tertiary) [17].

Both ANP and EP have rudimentary sense of self ("I") and exclusive access to some memories. Dissociative parts vary in degree of intrusion and avoidance of trauma-related cues, affect regulation, psychological defenses, capacity for insight, response to stimuli, body movements, behaviors, cognitive schemas, attention, attachment styles, sense of self, self-destructiveness, promiscuity, suicidality, flexibility and adaptability in daily life, structural division, autonomy, number, subjective experience, overt manifestations, and dissociative symptoms [18]. Dissociative symptoms include: negative like amnesia, numbness, impaired thinking, loss of skills, needs, wishes, fantasies, loss of motor functions or skills, loss of sensation; or positive when mental content or functions of one part introduce on another part's – psychotic/schizophrenioa like voices, nonvolitional behaviors, tics, pains; psychoform or somatoform=conversion symptoms. A dissociative symptom should be diagnosed only if there is: 1. Clear evidence of dissociative part and 2. Symptom is found in one or some parts but not in all parts [19-21]. But ANP and EP share: lack of full realization of the trauma, obstructive adaptive deficits, and significant dissociative symptoms.

Treatment Modalities (Psychotherapies)

Structural Dissociation (SD) is a permanent pathological state and requires treatment to fuse the parts. Social support and restorative experiences buffer negative post-traumatic effects. In therapy, three errors lead to EP intrusion: 1. Reification of parts 2. Undue emphasis of differences between dissociative parts and 3. Premature focus on traumatic memories. Precisely what we do in Cold Therapy in order to induce total breakdown of the internal Chinese walls [22]. When ANP well-functioning and dominant, PTSD is delayed and dissociative symptoms are latent. Functioning though is reduced compared to people who never develop PTSD. Where I differ from classic SD: to my mind, ANP fluctuates, periods of high-functioning alternate with periods of low-functioning, as in BPD (Borderline Personality Disorder) and NPD (Narcissistic Personality Disorder). The concept of collapse (submission, vanishing, freeze, fawn, flight) leads to covert behaviors (passive-aggression as a defense, for example) [23,24]. Collapse and mortification are traumatic and evoke past childhood traumas (when the child was castigated by not good enough primary objects as a bad, unworthy object).

CPTSD, BPD, DESNOS, OSDD

CPTSD (complex trauma), BPD and the now obsolete DESNOS (Disorders of Extreme Stress Not Otherwise Specified) all represent "Secondary Structural Dissociation", with Other specified dissociative disorder subtype 1 (OSDD-1) being the most complex of these disorders. Judith Herman, Driessen, McLean, Gallop, and many others argue for the diagnosis of C-PTSD: most C-PTSD is being misdiagnosed as borderline personality disorder and associated dissociative disorders. "The data on this point are beyond contention, 50-60 percent of psychiatric inpatients, and 40-60 percent of outpatients report childhood histories of physical or sexual abuse or both" [25]. OSDD-1 can teach a lot about this nexus of dissociation.

The difference between OSDD-1 and DID is the absence of amnesia or fully differentiated parts, not the number of ANP present. In most - though not all - cases, OSDD-1 patients have only one ANP and multiple well-developed and differentiated EPs, almost like the EPs in DID: they can range from the traumatic containers found in C-PTSD and BPD to fragments with some concept of differentiation to fully developed alters with their own full-fledged idea of self.

"EPs for those with OSDD-1 may handle some aspects of daily life such as exploration or play. They commonly perceive

themselves as children. They can either manifest through passive influence or, when in a safe environment or when triggered, through a full switch. The parts of those with OSDD-1 may deny each other, deny each other's' memories, or deny aspects of the body's physical form or current situation. Not only is the ANP avoidant of EP and liable to react to EP with shame, blame, or hatred, EP may avoid each other.

Not only that, but once one allows C-PTSD into the mix, the symptoms begin to sound more and more like borderline personality disorder, characterized by insecure attachment and emotional dysregulation, two key symptoms of C-PTSD in ICD-11. In other words, C-PTSD has little to do with trauma as it is normally understood and more to do with the subtle but severe traumas of childhood that lead to borderline personality disorder, such as lack of parental attunement, what D. W. Winnicott called being dropped by the mind of the mother".

References

1. Rothstein A (1984) The Narcissistic Pursuit of Reflection. Routledge, London.
2. Horowitz MJ (1975) Sliding Meanings: A defense against threat in narcissistic personalities. International Journal of Psychoanalytic Psychotherapy 4: 167-180.
3. Kernberg O (1975) Borderline Conditions and Pathological Narcissism. Jason Aronson, New York.
4. Stormberg D, Roningstam E, Gunderson J, Tohen M (1998) Pathological Narcissism in Bipolar Disorder Patients. J Pers Disord 12(2): 179-185.
5. Roningstam E (1996) Pathological Narcissism and Narcissistic Personality Disorder in Axis I Disorders. Harv Rev Psychiatry 3(6): 326-340.
6. Freud S (1905) Three Essays on the Theory of Sexuality. Standard Edition of the Complete Psychological Works of Sigmund Freud 7.
7. Alford CF (1988) Narcissism: Socrates, the Frankfurt School and Psychoanalytic Theory. Yale University Press, New Haven and London.
8. Fairbairn WRD (1954) An Object Relations Theory of the Personality. Basic Books.
9. Freud S (1914) On Narcissism. The Standard Edition of the Complete Psychological Works of Sigmund Freud 14: 73-107.
10. Golomb E (1995) Trapped in the Mirror: Adult Children of Narcissists in Their Struggle for Self. William Morrow & Company, pp: 272.
11. Greenberg JR, Mitchell SA (1983) Object Relations in Psychoanalytic Theory. Harvard University Press.
12. Grunberger B (1979) Narcissism: Psychoanalytic Essays. International Universities Press, New York.
13. Guntrip H (1961) Personality Structure and Human Interaction. International Universities Press, New York.
14. Jacobson E (1964) The Self and the Object World. International Universities Press, New York.
15. Trust MK (1964) The Writings of Melanie Klein. Free Press, New York 75.
16. Kohut H (1971) The Analysis of the Self. International Universities Press, New York.
17. Lasch C (1979) The Culture of Narcissism. Warner Books, New York.
18. Alexander L (1997) Narcissism: Denial of the True Self. Touchstone Books.
19. Millon T, Davis RD (1995) Disorders of Personality: DSM IV and Beyond, 2nd (Edn.). John Wiley and Sons.
20. Millon T (2000) Personality Disorders in Modern Life, 2nd (Edn.). John Wiley and Sons, New York 188(8): 558.
21. Ronningstam E (1998) Disorders of Narcissism: Diagnostic, Clinical, and Empirical Implications. American Psychiatric Press.
22. Lester S (1974) Narcissistic Personality Disorders - A Clinical Discussion. J Am Psychoanal Assoc 22(2): 292-306.
23. Daniel NS (1985) The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology. Routledge.
24. Vaknin S (2015) Malignant Self Love - Narcissism Revisited (10th revised impression). Skopje and Prague, Narcissus Publications.
25. Zwessig P (1968) The Heresy of Self-Love: A Study of Subversive Individualism. Basic Books, New York.