

The Central Role of Pathogenic Expectations and Beliefs in a Case of Intense Genital Damage Anxiety

Suzanne M. Gassner, PhD
San Francisco Psychoanalytic Institute

Pathogenic expectations and beliefs are constructions of reality, usually unconscious, that link frightening outcomes to the pursuit of normal developmental goals. These expectations, derived from past painful experiences, are conceptualized as a root cause for symptoms, repression, and other defenses. The first 5 years of an analysis are presented here to demonstrate how treatment technique is affected by an understanding of pathogenic expectations and beliefs as organizers of psychic reality and psychopathology. The major mutative force in this beneficial treatment was a process of gradually disconfirming the patient's expectations within a treatment relationship that the patient perceived as offering acceptance and empathic explanations of her psychic reality.

The case of Rachel is one in which the analysand improved steadily and dramatically as the intensity of her pathogenic expectations and beliefs was reduced. This occurred through a variety of means. Interpretations

Suzanne M. Gassner, PhD, San Francisco Psychoanalytic Institute, San Francisco, California.

I thank Harold Sampson, PhD, Johanna Krout Tabin, PhD, Joseph Weiss, MD, and Owen Renik, MD, for their helpful comments and suggestions.

Correspondence concerning this article should be addressed to Suzanne M. Gassner, PhD, 1491 Hopkins Street, Berkeley, California 94702. Electronic mail may be sent to smgassner@aol.com.

helped Rachel gain insight into the nature, origins, import, and current manifestations of her pathogenic expectations and beliefs. The primary purpose of these interpretations was to analyze and reduce the intensity of Rachel's fears. In addition they offered her a cohesive basis to feel organized and to appreciate the continuity of her life experiences. She also obtained emotional contact, development-promoting corrective emotional experience, and support in her relationship with her analyst. Jointly, we granted her the freedom to work at her own pace and to take the initiative, and I gave her as much time as she needed to get in touch with, evolve, and apply her understandings of her own psychology. One of Rachel's presenting symptoms was vaginismus. Penetration was painful, and therefore sexual intercourse in particular and heterosexual relationships in general were phobically avoided. The treatment led to the blossoming of Rachel's sexuality and to her eventually achieving a rich, intimate, and highly gratifying love life. She is now engaged to be married and living happily with her fiancé.

Clinicians who subscribe to psychoanalytic theories that a patient cannot overcome sexual symptoms and inhibitions without becoming aware of prohibited wishes and fantasies may have difficulty in accounting for Rachel's improvement and the underlying structural changes she made. When a patient such as Rachel becomes able to proceed fearlessly, what has happened to the posited wishes? This article addresses some of the theoretical issues that pertain to this case and describes in detail the course of the treatment in order to explicate and discuss the treatment process.

Pathogenic expectations and beliefs are distressing constructions of reality, usually unconscious, that link frightening outcomes to the pursuit of normal developmental goals. These expectations, derived from past painful and typically repressed experiences represent major enduring organizing rules that play a crucial role in patients' psychopathology. Pathogenic beliefs are at the heart of control-mastery theory,¹ both in

¹ The *control* portion of control-mastery theory refers to the idea that there is a part of the unconscious mind that is capable of regulation and that thinks, anticipates, assesses safety and danger, and exercises some control over its use of defenses. Our research group has conducted a series of studies that have demonstrated empirically that patients can exercise a certain amount of control and regulation over a particular kind of unconscious processing, namely the bringing forth of previously warded-off contents (Gassner & Bush, 1998; Gassner, Sampson, Weiss, & Brumer, 1982, 1986; Horowitz, Sampson, Siegelman, Wolfson, & Weiss, 1975; Shilkret, Isaacs, Drucker, & Curtis, 1986). The *mastery* portion of control-mastery theory refers to the premise that

terms of concepts of psychopathology and its treatment (Weiss, 1993). It is in obedience to the dangers that pathogenic beliefs warn against that a person maintains inhibitions, compulsions, and self-destructive behavior. Because these beliefs are grim, they typically are repressed or otherwise defended against. Weiss viewed his theory to be derived from Freud's later writings, especially from the formulation of the theory signal of anxiety (Freud, 1926/1954).

In this new theory, Freud viewed anxiety to be the cause of repression and symptom formation. Symptoms are now thought to serve the crucial function of removing the ego from a danger situation, and anxiety is the prerequisite for symptom formation. Freud concluded that the most distinguishing characteristic of the neurotic is the unconscious belief in childhood danger situations. It is the belief in childhood dangers that Freud viewed to be the ultimate determinant of anxiety, symptom formation, and repression. Freud's later theory has been used and elaborated by many ego analysts, such as Kris (1956/1975), Lowenstein (1954), Sandler (1960), Rangell (1969), Weiss (1971), Brenner (1982), and Gray (1995). Weiss has suggested that individuals have the capacity not only to repress a content that they judge would endanger them, but also to lift their defenses and to bring forth such a content if they decide that they can safely experience it. Weiss proposed that a patient may keep a content warded off until overcoming his or her anxiety about it and then bring it to consciousness without anxiety. If so, then one may expect repressed mental contents to emerge into consciousness frequently in analysis, even if those contents have not been interpreted, and to emerge without conflict and anxiety.

Freud concluded in his new theory of anxiety that anxiety has been shown to be "the defensive behaviour of the ego transfigured in a rational light" (Freud, 1926/1954, p. 146). Freud thought that neurotic individuals experienced anxiety in response to what was perceived to be an external danger: "An instinctual demand often only became an (internal) danger because its satisfaction would bring on an external danger—that is, because the internal danger represents an external one" (Freud, 1926/1954, pp. 167–168). This view contrasts with Freud's earlier hypothesis that the primary purpose of symptoms was to gratify unconscious wishes while concealing those very gratifications from oneself, and externalizing the

the unconscious ego is always ready to master an unconscious content that it had failed to master, once the ego judges that the conditions of safety are likely to exist. It is the imprint of traumatization and the need to ward-off retraumatization that conflicts with and inhibits such a pursuit of mastery.

responsibility, often to one's parents. In this view, reality is used as a defense against unconscious fantasy and protects unconscious drive gratification.

Many theoreticians have considered the formulation of the signal theory of anxiety to be a major turning point in psychoanalytic theorizing. Kris (1947), for example, stated that in "Inhibitions, Symptoms and Anxiety," "Freud reformulated a considerable set of his previous hypotheses. I am convinced that this reformulation reaches further than was realized at the time of publication, possibly by Freud himself" (pp. 25–26). And Wachtel wrote the following:

The implications of this reformulation were—or should have been—momentous. Freud had said on a number of occasions that repression was the very 'cornerstone' of psychoanalysis (e.g., Freud, 1915/1958). By now identifying anxiety as the motive underlying repression, Freud had in effect shifted the cornerstone. Anxiety, lying beneath and causing repression should have been the new candidate for the central grounding concept. . . . [A theoretical position that views] the patient's difficulties . . . as very largely a result of having learned to fear some of his most fundamental and powerful inclinations—is rooted in this newer understanding of the central role of anxiety. . . . The task of therapy, it appears in the light of these new formulations, is not so much to bring to light what the patient has wanted to keep hidden as to help the patient to overcome the anxiety that made the hiding feel necessary. (Wachtel, 1993, p. 39)

A range of differing and conflicting views can be found in the literature concerning the significance of the signal theory of anxiety for understanding psychopathology and technique. Even when the ideas were first formulated, according to Sterba in his *Reminiscences of a Viennese Psychoanalyst*, the theoretical change "was bewildering to some members of the group, since it necessitated the adaptation to a new way of theoretical understanding of clinical material" (Sterba, 1982, pp. 78). For psychoanalysts whose view of human nature emphasizes the endogenous motives as the root cause of psychopathology, the analysis of wishes and fantasies has remained the most fundamental task that the analysis undertakes. These analysts have not felt a need to modify technique in the light of Freud's later theory of anxiety. In contrast, Weiss agreed with those "interpersonalist" theorists who emphasize the primary role of relational experience in shaping drive expression and regulation, character formation, inner conflict, and psychopathology. Consistent with such theoretical preconceptions, Weiss interpreted the signal theory of anxiety as bringing trauma back into the etiology of neurosis. Traumatic experiences produce unconscious beliefs about danger which lead to the ego's instituting repressions through its purposive use of signal anxiety. Weiss asserted that

anxiety develops because a person unconsciously remembers past *experiences* in conjunction with instinctual wishes (Weiss, Sampson, and the Mount Zion Psychotherapy Research Group, 1986).

Brenner, like Weiss, has also elaborated on the meaning of Freud's formulation of an ego that is largely an unconscious structure capable of signaling the dangers associated with impulse expression. I interpret Brenner to be conceptualizing an aspect of unconscious fantasy that involves fearful beliefs concerning the nature of reality in general and the pursuit of wishes in particular. Brenner has described intrapsychic conflict as involving the link between instinct expression and the feared result of experiencing a core calamity of childhood, be it the loss of the object, loss of love, castration, or self-punishment (Brenner, 1982).

Brenner's formulations emphasized the important distinction between a drive, a generalization that applies to all persons, and a drive derivative, "a wish for gratification . . . that is unique, individual and specific" (Brenner, 1982, p. 26). He asserted that "what is important with respect to each patient is to learn as much as possible about what the patient wishes, about who is involved in his wishes and about how and why he has just those particular wishes about particular persons" (Brenner, 1982, p. 26).

Similarly, Weiss's pathogenic beliefs are specific and individual expressions of what each patient fears or considers forbidden. Such beliefs are fundamental to the understanding of neurosis because they prevent the patient from integrating her or his wishes into her or his more mature ego, and they organize the patient's psychopathology. In my view it is consistent with Brenner's concepts to consider how environmental factors including the pathogenic aspects of a parent-child relationship constitute a given patient's experience of the universal core calamities of childhood. Brenner's formulations help us to understand how frightening unconscious fantasies may link conflict, danger, trauma, anxiety, and defense (Brenner, 1982).

In dialogues about the relationship between Weiss's and Brenner's formulations, I have found an interesting pattern. Whether I discuss these ideas with highly experienced colleagues, editorial review boards, or advanced candidates in supervision, I have repeatedly found that some consider Brenner's views to be similar to and highly compatible with Weiss's, whereas others consider the two positions to be antithetical to one another. This controversy reflects, I believe, the disparate interpretations of the signal theory of anxiety. Some analysts think Freud brought the role of real experience and the pathogenic residues of trauma back into the

etiology of neurosis. Other analysts, by emphasizing the universality of the stages of anxiety or the dangers that the developing child will inevitably encounter, conclude that Freud was continuing to conceptualize the role of the drives as of primary importance.

I believe that the concept of pathogenic expectations and beliefs brings to the fore something that is of central interest to ego structuralists and relational analysts alike, namely patients' anxiety-ridden anticipations about what will happen to them in relationships. Various relational theories emphasize the importance of pathogenic expectations with their introduction of highly specific concepts such as unconscious organizing principles (Stolorow & Atwood, 1992), internal working models (Bowlby, 1988), model scenes (Lichtenberg, Lachmann, & Fosshage, 1992), representations of interactions generalized (Stern, 1985), and cyclical psychodynamics (Wachtel, 1993). Despite there being substantive differences between these relational theories, they all give central importance to how pathogenic expectations, conscious and unconscious, organize psychopathology, resist change, and serve adaptational and relational purposes. The analysis of such expectations is seen by relational analysts as essential to freeing patients from enslavement by their anxiety-based unconscious or dissociated pathogenic convictions.

In each of these relational theories, what I am terming "pathogenic expectations and beliefs" are a product of the traumatic experiences in an individual's life, as he or she construes them, and the warded-off memories and painful affects associated with the resulting unconscious conflicts. Although such theories are sometimes criticized for their focus on external reality, pathogenic beliefs are actually internally motivated, subjective, organizing rules that oftentimes are the source of conflict and that underlie symptoms and inhibitions. According to these theories, key factors that contribute to a psychoanalysis producing structural change include (a) increased conscious access to frightening, unconscious beliefs and their associated painful affects; (b) insight into the ways that such beliefs and expectations shape psychic reality; and (c) emotionally powerful new experiences with the analyst that foster change in patients' pathogenic beliefs and expectations. In each of these relational theories, structural change can be inferred when there is a diminution in the power of external reality events to activate the pathogenic beliefs and expectations and their associated painful affects.

As a member of the San Francisco Psychotherapy Research Group, I have been particularly influenced by the work of Sampson (1986) and Weiss (1993), who have developed and conducted research on the concept

of pathogenic beliefs. Whereas many relational analysts developed theories that were extensions and modifications of Kohut's work, Weiss's ideas are rooted in ego psychology. In Weiss's theory, pathogenic beliefs are generalizations about the conditions of safety and danger that are drawn from repressed memories of traumatic experiences. The various dangers that such beliefs take into account include (a) the threat of being overwhelmed by the strength of one's instincts; (b) painful internal experiences of fear, shame, guilty self-torment, or remorse; and (c) the perceived consequences of pursuing one's inclinations leading to a disruption in one's primary relationships (Bush, 1986). Pathogenic beliefs are not necessarily instances of compromise formations and are not formed by primary process mechanisms. Instead, they reflect the unconscious ego's adherence to the reality principle rather than to the pleasure principle. Although instinctual impulses enter into the development of pathogenic beliefs, experience enters into the formation of these beliefs as an independent factor.

I believe the concept of pathogenic beliefs provides a bridge between analytic theories that emphasize the role of wishes in shaping psychopathology and analytic theories that emphasize the role of traumatic relational experiences. A pathogenic belief concerns the

dangerous consequences of experiencing or attempting to satisfy certain wishes. Because this kind of unconscious belief plays a crucial role in producing repression and in maintaining conflicts and symptoms, we consider it useful to distinguish it from other mental products such as simple wish-fulfilling fantasies, [and] other kinds of unconscious beliefs . . . [that are] reassuring. For example, the belief that women have penises is not what we mean by a pathogenic belief. That belief, as Freud noted, *denies* the patient's pathogenic belief, i.e. his belief in castration. (Sampson, 1985, p. 15)

Pathogenic expectations and beliefs describe powerful organizers of internal mental life by taking into account how the perception of reality is inevitably shaped in part by wishes and needs. The concept may not resolve the controversy concerning whether these expectations are based primarily on repressed wishes or on inferences drawn from experience, with all of their subjective constraints.

The Case of Rachel

Rachel entered treatment unaware of the traumas from which she suffered. She and I came to believe that her serious problems with constipation and the periodic rectal fissures from which she suffered constituted a trauma of

central importance.² Rachel suffered from her first rectal fissure when she was just 6 months old. Although she did not have her next rectal fissure until she was 12, she routinely experienced intense pain, fear, shame, and emotional isolation while having a bowel movement. Thus, this bodily trauma led to her being unable to exercise control over her bowel function, a function whose very purpose normally is one of providing a means for control.

During the course of Rachel's analysis it also became clear that she suffered from some family-based strain traumas that contributed to her pathogenic expectations and fears. In different ways, she experienced each of her parents as contributing to her fear of being out of control. Although there is clear evidence for the role of reality in shaping these perceptions, it is undoubtedly the case that Rachel's bodily trauma colored her experience of her family in a particular way that further complicated her relationships with her parents.

Rachel's Pathogenic Beliefs and Expectations

In order to orient the reader to Rachel's fundamental underlying anxieties, I first describe her pathogenic beliefs and expectations abstractly. When we began our work, it was my impression that these beliefs were unacceptable to her and warded-off by defenses such as compartmentalization, isolation of affect, and undoing—that is, they were dynamically unconscious. Her conscious beliefs about the issues that I describe were far more realistic. Her pathogenic beliefs seemed to be omnipresent and organized her conceptions of events with regards to all kinds of experiences that she reported in her daily associations. In practice, my actual interpretations addressed her specific associations, anxieties, and worries, which I understood to be the manifestations of these pathogenic beliefs and expectations.

Rachel believed that the only safeguard against feeling helpless and out of control was to be constantly vigilant and to exercise tight controls

² My understanding of what caused Rachel to suffer from a rectal fissure as a 6-month-old is as follows. Rachel was breast fed during the first 5 months of her life. When she was changed from breast milk to formula, she became very constipated, and the seriousness of the problem was not fully manifested until she developed a rectal fissure, an actual bowel tear that caused her feces to be quite bloody. Since working with Rachel I have learned of several other infants who shortly after being switched from breast milk to formula became constipated and subsequently developed rectal fissures.

over all of her desires. Across all areas of her life, Rachel seemed to believe that the danger of relaxation was that she would lose the ability to be self-regulating. This belief was manifested by her compelled need to maintain tight controls over her food intake, her exercise regimes, her cleanliness and orderliness, her interpersonal interactions, and her experience of our relationship. Her academic and professional ambitions were inhibited by her compelled need not to tackle a task unless it was a foregone conclusion that she could master it with ease.

Rachel subscribed to a pathogenic belief that femininity in general, and sexual intimacy with a man in particular, necessitates the relinquishment of autonomy. Although this expectation dominated her experience of heterosexuality, all of her relationships were shaped by the related dire belief that she could only be somebody to somebody were she willing to be nobody to herself. If she hoped to have an intimate attachment, she had to be prepared and was compelled to sacrifice her identity, her sense of her integrity, and her authenticity. Rachel unconsciously believed that the unavoidable price for having a sexual relationship was to experience physical pain and damage as well as emotional violation. The unrealistic danger she associated with being a sexually successful woman was the requirement that she sacrifice access to her feelings and that she willingly endure physical discomfort, pain, and damage as well as emotional violation in order to protect the man's inevitably fragile self-esteem.

Rachel developed these pathogenic beliefs in response to the bodily trauma that she had suffered combined with a prominent set of unconscious beliefs that she developed as she internalized certain destructive aspects of her family relationships. At the beginning of our work, these mostly unconscious beliefs left her struggling between intense feelings of loneliness and isolation and the alternating feelings of despair that followed her brief, unsuccessful forays into highly unsatisfying heterosexual relationships.

My alertness to these underlying pathogenic expectations and beliefs enabled me to respond to the various manifestations of her specific fears and anxieties in ways that seemed to leave her feeling understood and accepted. The analysis of these interrelated pathogenic beliefs opened up lines of interpretation that enabled her to overcome her anxieties about genital damage and to relax many of her inhibitions.

The Nature and Course of Rachel's Treatment

The case report that follows is intended to serve two purposes. My main purpose is to demonstrate repeatedly how the concept of pathogenic

beliefs shaped my case formulation, my interventions, and the relationship that I co-created with my patient. In addition, because a case report can only illustrate but not prove a point of view, I want to provide enough of the entire context of the treatment that readers can juxtapose their own understanding of the course of the treatment and its mutative factors with those that I describe. The treatment details that I provide are intended to invite consideration of the significance of pathogenic beliefs for organizing and understanding a treatment process.

In describing the sequence of treatment events, I am recounting my patient's account of her psychic reality. Needless to say, I am not in a position to assert the veridicality of her perceptions as historical data. It is inevitable that my patient's depiction of her history and her relationships is itself shaped in part by her pathogenic beliefs and transferences.

When first I met Rachel she was a pleasant, tall, blond, casually dressed, slightly overweight 25-year-old. She presented as a high-spirited woman who exuded vitality and earnestness. It became clear that she was blessed with some special strengths. She had graduated from a prestigious mid-western college with a straight A average. Her musical talents enabled her to perform on a part-time basis as a jazz pianist. By all reports she was loved by family and friends alike.

Nonetheless, Rachel was also tormented by serious emotional problems. She came to treatment adamantly stressing in her initial interview that she would not meet with me more frequently than once a week. While in college, she had spent 2 years with a highly respected and experienced male analyst. From the little she told me, it was clear that she had found the analysis to be upsetting, humiliating, and unproductive. When she became convinced that the analysis was at an impasse, she fled from any further treatment for a 2-year period. Now she was only willing to consider once-a-week treatment with a female psychotherapist.

Rachel's initial complaints focused on her difficulties establishing any relationship with a man. She had never dated any man for a period lasting longer than 3 weeks. There was a clear pattern that characterized these short-lived relationships. In response to Rachel's initial attraction to a man, she allowed herself to exchange a kiss. She viewed the kiss as a promise that obligated her to have sexual relations. Rachel believed that in order to be feminine, she had to make the task of pleasing a man her top priority. When Rachel forced herself to have intercourse, she found penetration painful, intercourse ungratifying. Worse yet, Rachel would feel she had compromised her own integrity. She suddenly found her partner sexually unattractive, ugly, and repellent, and she fled from any

further contact, all the while feeling profoundly guilty and defective. As she put it, she was “weird” to have reactions so diametrically opposite those she initially had had when first motivated to develop the relationship.

Rachel and I worked together for 2 years in psychotherapy before she felt ready to resume psychoanalysis. Initially Rachel expressed great distress about her inability to maintain any interest in a man once she tried to have intercourse with him. Rachel suffered from other noteworthy symptoms. She reported an eating disorder that began at the age of 14 when she lost 15 pounds through dieting. She was then 5 feet 7 inches tall and weighed only 110 pounds. While in college, Rachel began using laxatives and had continued doing so at the time she first contacted me.

It was of particular interest that her eating disorder involved laxative abuse because she had suffered from rectal fissures, her first one occurring when she was just 6 months of age. Her most recent rectal fissure had begun 4 years earlier, and she was continuing to suffer from it. Rachel had intermittently tried to get help from physicians but had failed to work out any regime that would allow the rectal fissure to heal.

My approach to our early sessions was far from original. I tried to encourage Rachel to discover what her thoughts and feelings were with regards to any topic she raised. Because Rachel seemed to feel that her right to exercise her autonomy was in such jeopardy, I also avoided introducing any agenda of my own, including even a shift in emphasis to focus on her experience of our relationship. Instead I pursued the details surrounding the experiences that she wished to explore. My technique was based on the assumption that it would be a precondition to her gaining an increasing sense of safety with me that I avoid doing anything that she would experience as overriding her right to have and pursue her own thoughts and feelings.

In this opening phase of treatment I told Rachel that my impression was that it would be very difficult for her to enjoy sex with a man until she was able to find a way to get her rectal fissure healed. I had concluded that Rachel’s physically painful experiences with heterosexuality were only serving to strengthen her pathogenic belief that she was a physically defective woman who was innately incapable of enjoying genital pleasure. I inferred that she had generalized from her experience of pain when expelling feces to the experience of penetration in intercourse. I assumed that a precondition for Rachel acquiring the ability to relax while being genitally stimulated was that she experience herself as having a sturdy and healthy body. Until this was accomplished, I thought that her repeating her distressing experiences of sexual intercourse would serve only as addi-

tional proof of her defectiveness. Moreover, such experiences would only strengthen her conviction that she was incapable of having a love relationship without sacrificing her autonomy and identity.

Without any discussion, Rachel readily embraced the idea of trying to find a way to heal her rectal fissure. She recognized that she would like to get help with her eating disorder because she had to have much greater control over her diet if she were to have any hope of succeeding at resolving her bowel problem.

Rachel's history helped me understand some of the determinants of her presenting symptoms. Throughout Rachel's treatment she consistently conveyed the impression that she was blessed in having unusually loving, generous, well-intentioned parents who were devoted to providing her with excellent care and guidance. Rachel initially described both of her parents as flawless. As her defensive use of idealization decreased, she began to face some of the "psychopathology of everyday life" that she had considered as routine in her family, and her perceptions of the problematic features of her own interactions with her parents also emerged. It also became clear that each of her parents had been exceptionally successful in overcoming very difficult experiences of their own.

Father's history is of particular interest, given Rachel's eating disorder. Rachel's paternal grandmother died when Rachel's father was 7. He is reported to have become very overweight after his mother's death, and he remained overweight throughout his childhood. Rachel characterized her father as needing to be in extreme control of everything. He keeps a strict account of his weight, and if it goes up 1 pound he goes on a diet. He urged Rachel to do likewise. Rachel views her father as putting a great emphasis on appearances—being thin, neat, and organized—and in these regards she reported having modeled herself on her father.

Rachel understood her father as wanting her to be conventionally feminine and admiring of men. Yet he also encouraged her to achieve athletic proficiency. Rachel reported that she hated sports and was very fearful of injury. She described how extremely contemptuous her father was of fear as an emotion. She reported that despite her fear, her father forced her to learn to swim, play tennis, ride horses, and play soccer. At age 6, while horseback riding, she suffered a severe fall. As a result of her injury she needed to wear a leg brace for a period of a year. Rachel was particularly distressed by the need during that year to rely on the use of bed pans. On the basis of Rachel's associations to this point, I drew the conclusion that it was a time in Rachel's life in which her grim conviction was further consolidated that she was defective and incapable of exercis-

ing normal controls over her body and its functions. She also developed a heightened sense of her vulnerability to physical injury and an intensified unconscious resentment of her father's requirement that she engage in athletic activities despite her wishes to the contrary.

The bed pan regime prevented Rachel from exercising the kind of "control" she had been using to postpone bowel movements and the associated pain she anticipated with terror. Prior to the accident she had been standing up and squeezing her muscles so tightly that her legs would shake. As best I can tell, the bed pan routine cured Rachel's self-induced constipation.

Rachel's mother came from a poor family. When Rachel was 16, her mother became ill with a rare, life-threatening disease of the uterus. Fortunately, her mother survived her illness. Apparently this was a major turning point in her mother's life. She began a period of intensive psychotherapy. According to Rachel, before the psychotherapy, her mother had been highly submissive to her father's dictates and had subordinated major goals in order to appease her father. After almost losing her life, Rachel's mother was experienced as becoming considerably more assertive and as giving significantly more attention to her own aspirations and purposes.

Rachel was understandably frightened by the seriousness of her mother's illness. My impression is that it further heightened Rachel's unconscious worries about the vulnerability of the female reproductive equipment. Nonetheless, Rachel was also very relieved to see her mother becoming less self-sacrificing. Over time, Rachel expressed the view that her anxieties about being female were based in part on the experience of watching her mother behave as her father's doormat.

During the early phase of the treatment, our work focused on Rachel's pattern of being too good a girl and on her eating disorder. The two problems proved to be interrelated. Rachel began to struggle to become the kind of woman she wished to be. She no longer wanted to live up to her father's standard of femininity. She began to test her convictions about both the urgency to be feminine and what femininity requires.

Rachel initiated actions in what I understand to be an effort to disprove the pathogenic beliefs that defined her gender role identity and that contributed to her feeling unable to protect herself. She cut off her long hair, stopped wearing makeup, and got several inconspicuously placed tattoos. She reduced the frequency of her exercise routines and she began taking a series of self-defense courses, courses designed to help a woman protect herself against an attacker, including a rapist. She also

began actively to voice her disagreements with her father rather than submitting to his viewpoints. She reported her father's discomfort with her "less feminine" behaviors and worried about the disruptive effect these changes were having on their relationship. Rachel was becoming conscious of suffering from a pathogenic belief that being authentic would inevitably lead to not only her father but men in general rejecting her and finding her unappealing.

As part of Rachel's difficulty with acting authentically on the basis of her own beliefs she frequently had the experience of losing access to her own feelings. She reported having felt compelled to adopt the attitudes and beliefs of the men she dated, as if the revelation of differences would lead to her being found unappealing. I told her that her cold and angry feelings toward men might be related to the ways she negated her own authentic feelings, most of all at those times when she dutifully agreed to "get it over with"—that is, to have intercourse.

Rachel responded by stating that she thought her eating pattern was similarly based on disregard for her own feelings. She was becoming aware of her compelled need to submit to her father's dictates. In keeping with father's instructions, she had tried unsuccessfully to follow very strict dietary and exercise regimes and to override her subjective experience of hunger or fatigue. Periodically she would fail to maintain the discipline that father thought necessary. She would then condemn herself for failing and view herself as incapable of maintaining the needed impulse control.

Rachel began to experiment with giving more credence to her own dietary desires. She relied more heavily on her subjective states to determine when to eat and how much to eat. She allowed herself to include desserts in her meals. She gave herself permission to skip exercising on days when she simply was not in the mood and thereby began to gain a greater sense of control of her weight and her overall health.

While doing this work, Rachel gained an awareness of the strength of some of her pathogenic identifications with her father. She also became aware that she did not feel free to question her father's beliefs, particularly his view, as she understood it, that all desires have to be tightly controlled and held in check.

Rachel spent many hours discussing her diet, exercise patterns, and her rectal fissure. She expressed surprise that I seemed interested. She reported that her prior analyst had told her that these problems were symptoms of something else, and she had assumed that he did not want her to discuss these mundane matters with him. They had dropped out of her "free associations." Rachel seemed to be slowly learning that her subject-

tive states had validity and that she could use such cues to become more self-regulating. Rachel was excited to see that by trusting and validating her bodily cues she was able to make progress with her eating disorder. This new approach represented a repudiation of what she believed her father had taught her about the strategies one needs to maintain self-control. She struggled with feelings of guilt about disloyalty to father as she made progress overcoming one of her unconscious pathogenic beliefs, namely the urgent importance of maintaining tight controls to avoid being totally out of control.

As Rachel began to feel freer, she became interested in increasing the frequency of her sessions to twice a week. I learned that in early childhood Rachel had been encouraged to take showers with her father and at other times baths with her two brothers, siblings who are close in age to Rachel. Bathroom doors were not closed and father in particular encouraged nudity in the home. Her father routinely patted the patient's bottom until recently when she found the courage to confront him about the inappropriateness of his familiarity. Despite such confrontations, her father still persisted in this behavior, although its frequency diminished.

In response to Rachel's early bowel symptoms, her mother had taken her to a child psychoanalyst. Rachel's understanding is that the child analyst had advised her mother to stop bathing her then 5-year-old daughter with her sons. But her mother reported having been unable to stand up to her father, who wanted to see the practice continued. I inferred that Rachel understood her mother's failure to implement the child analyst's recommendation as further proof for her pathogenic expectation that the price for having a heterosexual attachment is to sacrifice one's integrity and autonomy.

I began to explore the possibility that Rachel's inability to get involved in a relationship with a man was connected to her experiencing her father as wanting her to submit to him and to admire him sexually. Rachel elaborated on this theme. She felt that she had learned from mother that femininity requires submitting to a man's whims. Previously warded-off memories emerged concerning instances when her father pressured her mother's compliance. Rachel expressed mounting distress as she described father's past and ongoing jibes, put-downs, and generally contemptuous attacks, responses she believes made to coerce her mother and her to comply with his wishes. New material also came forth about her mother's earlier psychological vulnerabilities and her characteristic stance of self-sacrifice and self-neglect.

Rachel began revealing more about her perceptions of her father's

contempt for the opposite sex. She found it particularly upsetting to remember the ways her father would ridicule her mother for her emotional responsiveness to poignant movies or novels. During this phase of the work, she began to view her father as completely insensitive to all human feeling, devoid of empathy, out of touch with his inner feelings, altogether emotionally “without a clue.” I commented about how Rachel’s view of her father had seemed to be generalized to all men whom she was seeming to view now as aliens. Although she could recognize how stereotyped her perceptions of men were, she retained her pessimism about ever finding an emotionally open and responsive man.

Rachel began to disclose the myriad of ways that father expressed contempt for family members when they manifested characteristics different from his. Rachel felt that her father was also aggrandizing about his distinctive areas of strength; he imposed the judgment that everyone should excel in just these arenas. She noted that these were the same areas that gave her the most difficulty and that she tried to avoid.

Because Rachel had so much difficulty maintaining her own distinctive personality when in the company of a man she hoped to seduce, I began interpreting her pathogenic expectation that differences—whether in one’s values, talents, or interests—inevitably threaten relatedness. I interpreted Rachel’s compulsion to behave like a chameleon as reflecting the distressing belief that differences, once recognized, result in people dismissing, disdaining, and rejecting one another.

Rachel linked these ideas to early memories of wishing to have a penis and be like her father. She then recalled a later period in her life when she became eager to become a mature woman. She described in vivid detail the endless wait to develop breasts and to have her first period. When the long-awaited milestones were finally reached, she recalled the excitement and enthusiasm she felt and the recognition and approval she received from both her parents. Yet she realized that her current view was still that it is better to have a penis. She asserted that sexual intercourse provides men with far more pleasure and spares them the pain she routinely experiences with penetration.

After 2 months of twice-a-week treatment, Rachel asked that we begin meeting on a 3-times-a-week basis. Rachel also began consulting with a proctologist and an acupuncturist. She was no longer manifesting any of the symptoms of her eating disorder and she was eager to develop a regime that would help her heal her 6-year-old rectal fissure. Rachel had made some gains in overcoming her pathogenic belief that relaxation inevitably leads to losing the ability to be self-regulating. She was becom-

ing more relaxed about some of her physical desires and better able to use her bodily cues to regulate her eating and exercising regimes. Four months later, Rachel announced with great delight that her rectal fissure was entirely healed. She reported a wish to begin meeting 4 times a week and using the couch. She also announced that she was ready to end the 2-year hiatus that she had taken from dating men.

I understood Rachel's readiness to come 4 times a week as an achievement. She had self-dosed the frequency of her sessions and now was announcing her readiness to explore deeper material. I hoped that in this phase of our work I would come to understand more about her transference expectations and the seemingly strong alliance she had formed with me. Because she had begun the treatment idealizing both of her parents, I was particularly concerned about what failures of my own were being warding-off given that I now had, it appeared, become the target of her idealization.

Simultaneous with Rachel's move to the couch, she began dating men, and she continued working on her conflicts about self-assertion. She seemed to be feeling more confident in part because she saw that the more responsibility she took for voicing some of her complaints directly to her father, the more he had taken responsibility for making some significant changes, and thereby their relationship had improved considerably.

Rachel's approach to free association was constricted. She typically presented material in a controlled, highly-organized, focused fashion. We continued to examine the specific manifestations of her pathogenic belief that if she allowed herself to relax, she would lose the ability to be self-regulating. She came to recognize that this same conviction that had affected her eating and exercising patterns was affecting our relationship too. She became curious to explore its effect on her study habits as well as on her approach to free association. Gradually, she became aware that she actually considered it unfeminine to be self-regulating and in control. I interpreted specific instances in which she acted as if she had to choose between being feminine and being herself, observations she readily confirmed. This work led to her becoming more relaxed and spontaneous in the hours. She also began recalling a good deal more about her earlier period of psychoanalysis.

Rachel described her former analyst as rarely saying anything to her. Periodically, however, she recalled his telling her how he saw her trying to control the analyst and the analysis. Rachel began to disclose not just the humiliation she felt, but the accompanying hatred of him that she developed.

My understanding of this impasse is that the prior analyst's interpretive tack inadvertently reinforced the patient's belief that only an unfeminine, bad girl would long to exercise her autonomy. A good girl would be happy to have the man, in this case, her analyst, control her. Because Rachel compulsively defended against this dire belief that femininity requires submissiveness, her analyst was undoubtedly describing her behavior accurately but not interpreting the underlying anxiety that was motivating it.

Rachel had been unable to express any of these self-blaming, self-punitive reactions. She revealed that toward the end of this analysis, she frequently went into the bathroom after her hours and slapped herself in the face. Given Rachel's negative, paternal transference, it is not surprising to learn that she had been unable to confide either her negative feelings or her self-punitive behavior to her male analyst. Rachel began to see that it might have been possible for her to have made progress with her prior analyst had she dared to share any of her reactions with him. But that was impossible for her.

Rachel had felt misunderstood when her prior analyst interpreted her wish to control him and the analysis. But she worked progressively in response to interpretations that communicated my understanding of her underlying pathogenic expectation that I might use my position to control her and interfere with or undermine her freedom to experience herself authentically. I believe that it was in response to this underlying anxiety that Rachel manifested a wish to control the relationship. As I detail later, it took us many years before Rachel could become fully aware of how compelled she constantly was feeling to control herself and our relationship, because unconsciously she was always feeling in danger of being controlled and dominated.

I asked Rachel, given her discomfort with sharing feelings with men, how it was that she had chosen to see a male psychoanalyst. She reported that since she was living far from home, she had relied on her beloved child psychoanalyst to give her a referral. At that time she was so unaccustomed to considering her own feelings in such matters that she had felt compelled to accept his recommendation. She felt far too inhibited to initiate a discussion, even with him, about what she perceived her needs to be.

Rachel told me a great deal about the importance of her relationship with this male child analyst whom she saw for 3 years beginning at age 3. Her mother had sought help for her little girl who had been suffering from

constipation. Rachel has continued to cherish that early treatment experience.

Rachel began at this point to take a new tack with men, because she was feeling more capable of staying in touch with her inner feelings and at times expressing them directly. She struggled with the following dilemma. She wanted to be neither overly controlling like her father nor submissive and self-sacrificing like the mother of her childhood. Gradually she was able to begin relating to men in the ways she wished, and the relationships were now longer lasting. However, she still felt a dread of intercourse.

Much of what Rachel said suggested that she held to a pathogenic belief that she was a defective woman whose body could not provide normal sexual pleasure. Her dread of intercourse shifted following a very specific interpretation that I made. I pointed out that her fantasy of intercourse seemed more connected to the experience of having bloody bowel movements than to the familiar pleasure that she routinely experienced with masturbation. Rachel was quite astonished to realize that this was so. She also reported that the one man with whom she had dependably been orgasmic was someone who had an unusually small penis. It was clear to both of us that this man did not trigger her pathogenic expectation that penetration would lead to genital pain and damage.

Following these interchanges, Rachel began exploring sexual relations with a newfound enthusiasm. The sexual experiences very gradually became increasingly pleasurable. She reported experiencing more lust, and I assume was lubricating readily because penetration was no longer feared or painful. After an additional 1½ years of dating, she entered a relationship with a man whom she viewed as sensitive and caring. She not only was able to have her first long-term relationship with this man but was able to experience what she described to be blissful sexual relations.

I knew that our relationship had entered a new phase when she stated that she had a confession to make. She told me that for years she had been thinking of me as like Terry Gross, the National Public Radio's renowned interviewing host of Fresh Air. While talking about this fantasy we both noted that she was unable to stop crying. As I happen to be very admiring of Terry Gross, I was particularly puzzled by her labeling this long-standing fantasy a "confession." I asked Rachel to tell me more about this view of me. Her elaboration continued to be an expression of her idealizing transference. She continued to cry as she talked about how smart we both were, the similarity of our senses of humor, and the pitch of my

voice. Rachel and I were at a loss to explain how it was that even this expression of admiration and affection caused her to sob.

Rachel now became considerably more interested in exploring her experience of our relationship. She had hitherto related politely to my interpretations of transference expectations, but she had never initiated any extended exploration of the emotional impact of our relationship.

Rachel had consistently cried when voicing even the most minor of complaints. I was quite surprised by the intensity of her affect the first time she was mildly critical of my being late to start our session. She was unable to stop the sobbing that accompanied her expressions of dissatisfaction.

Now Rachel was viewing her freedom to be intimate and spontaneous with me as a major new phase of her analytic work. She began making observations about momentary and subtle shifts in my mood. On one occasion, for example, she worried that I was upset about something. Because I considered myself to be in a very fine mood I was initially puzzled by her concern. When we explored her perceptions she mentioned that even though I had smiled when I first greeted her, that a serious expression had passed over my face while she was walking into my office. It took me a while to make sense out of her observations. I told her that after she mentioned this concern I became aware that my thoughts had momentarily flashed on a troublesome phone message I had received earlier that day. I told her that she had been more aware of how I was feeling for that moment than I myself had been. During interchanges such as this one I was impressed and touched by her capacity to be astutely attuned to my own state of mind.

During this phase of our work Rachel also began describing vividly her difficulty confronting her mother with any of her negative observations. Should Rachel voice any criticism to her mother in any way, Rachel experienced her mother as dismissing the complaint by explaining what it was about Rachel's personality or stage of development that underlay Rachel's voiced dissatisfaction. In response, Rachel would lose her bearings. Gradually Rachel came to see that throughout our relationship she had been warding off her fear that I would convert any of her perceptions of me into "helpful" reformulations about her immaturity or her emotionally based misunderstanding of "the truth." Because of the intensity of her attachment to me, as with her mother, she unconsciously was highly motivated to avoid provoking such a disruption from occurring. She had been protecting herself from the experience of feeling that her very sense of herself might be raped, her independent thoughts and observations

invalidated. It became clear to us that Rachel had been unconsciously frightened that were she to make observations of any kind about me, even those that were overt expressions of gratitude and love, that I would avert the expression of intimacy by misinterpreting her feelings to be an expression of her psychological problems.

Rachel now elucidated some important ways that she believed her mother had discouraged intimacy. When her mother had been seriously ill, Rachel remembered that neither her mother nor her father initiated offering her information about her mother's illness, its course, or treatment. Rachel inhibited herself from voicing many of her questions and only allowed herself to experience her intensely painful feelings when she was alone. Rachel felt comparably isolated from her family when it was she who was suffering from severe constipation. Her mother diligently sought medical help for her daughter, but Rachel has no memory of her mother's attending to the emotional significance of what Rachel was experiencing.

It was painful for Rachel to realize that when anxious, her mother had exercised indirect control in their relationship. Throughout the treatment Rachel had provided a wealth of very convincing evidence about how devoted, kind, generous, understanding, and loving her mother had been in most regards. Now she was considering her perceptions of her mother's disavowed pattern for discouraging Rachel from thinking independently about her mother's limitations. Only after exploring the maternal transference were Rachel and I able to understand the depths of her previously ward-off fears that ongoing exploration in an intimate relationship would lead to her losing control over her own thoughts and feelings.

Following this work Rachel began confronting her mother when she believed her mother was behaving badly. She persisted in voicing her complaints and refused to allow her mother to pressure her to relinquish her own perceptions. From Rachel's point of view her relationship with her mother improved dramatically. Once Rachel had become freer to discount her mother's pathological attributions, she was able to maintain her confidence in the validity of her own perceptions. This change enabled Rachel to enjoy a more authentic relationship with her mother.

A year later Rachel fell in love with the man whom she now plans to marry. Moreover, for the first time in her life, Rachel has been finding herself eager and confident about becoming a mother. During the past year of the analysis, Rachel has been exploring her conflicts about relating more spontaneously and intimately with both her fiancé and her analyst. She has become increasingly aware of how throughout the analysis she has

feared my power to control her, criticize her, or dismiss her perceptions. Rachel has been disconfirming her transference expectation that our relationship can readily be destroyed by her more freely voicing her perceptions of the interchanges that comprise our daily analytic hours. Gradually she has come to see that the more she experiments with sharing her daily perceptions of our relationship the freer she becomes to be more spontaneous and intimate with her fiancé.

Discussion

Rachel entered treatment suffering from an overdetermined set of pathogenic expectations and beliefs concerning the dangers associated with a loss of control. Over the course of the analysis it became increasingly clear that this fear was rooted in early traumatic experiences of pain and psychic helplessness that were associated with repeated experiences of severe constipation and rectal pain. In Rachel's first analysis as an adult, she recalled repeatedly being told that she was trying to control the analyst. Although this interpretation was undoubtedly accurate, it was experienced by her as meaning that she should relax her controls and allow the analyst and the analytic process to take her over. This line of interpretation retraumatized her and confirmed her fear of having control taken away from her. In order to analyze her fear of helplessness she needed to experience the relationship with her analyst as one where her autonomy would be respected. Instead, the first analyst's line of interpretation heightened her fear that analysis would expose her once again to being out of control and psychically helpless. Moreover, the cumulative impact of this line of interpretation was that she increasingly felt guilty for being a bad patient who opposed the work. Shortly before breaking off her first analysis, she developed a severe masochistic symptom. She began slapping herself in the face following her hours in an effort to punish herself for what she came to believe was her unacceptable wish to control the analysis and the analyst. On the basis of other data, I would infer that she was unconsciously punishing herself for the "crime" of wanting to separate from and reject this analyst.

Rachel's fear of the loss of control also influenced her gender role identity (Tyson, 1982). She held to the frightening though unconscious belief that sexual intercourse would inevitably cause her physical pain and result in genital damage. I understood an early and major determinant of Rachel's fear of damage to her genitals to be her lifelong struggle with rectal fissures. Over time, I inferred that she feared that penetration could

result in her developing "vaginal fissures." Arlene Kramer Richards described in general terms the interrelationship between a girl's bowel sphincter control and genital sensation:

I believe that the sense of mastery that the girl achieves in controlling her sphincters is magnified by the sexual pleasure she achieves by this . . . It seems to me that the fear of the loss of this capacity, experienced as fear of forcible penetration or rape, is the basic female sexual fear. (Richards, 1992, p. 341)

It should be noted that in this formulation the fear of rape is fundamental, in contrast to some classical theory-based formulations that might consider such a fear also to be a wish or a defense against such a wish. Richards's formulation highlights the relationship that might be expected between a girl's early chronic bowel dysfunction and her subsequent difficulty with genital functioning. Her perspective helps elucidate a possible determinant of Rachel's pathogenic belief concerning the dangers of sexual intercourse.

It is my impression that Rachel's rectal vulnerability, though a powerful determinant, was nonetheless only one of the factors that contributed to her pathogenic beliefs about femininity. Her fears seemed secondarily to be a reflection of the power imbalance that Rachel reported having observed as the daily fare in her parents' relationship. In addition, these beliefs seemed to reflect the "working models" of interpersonal relations that Rachel developed as she internalized the disturbing aspects of her interactions with each of her parents.

My formulation of Rachel's pathogenic expectations and beliefs enabled me to understand the ways she had construed her earlier experiences, experiences that shaped her symptoms and governed her transference relationships with each of her two adult psychoanalysts. These conceptualizations led to my opening up lines of inquiry and interpretation that helped Rachel to overcome past miseries. By sharing with Rachel my understanding of her unconscious pathogenic expectations and their manifestations in the transference, I was able to assist her in her efforts to relax many of her inhibitions and to reduce her anxieties about genital damage. As Rachel freed herself from believing in the unconscious expectations that had been governing her, she gained the capacity to form powerful new attachments and to think, feel, and act in new ways with her parents, her lovers, and her psychoanalyst.

According to control-mastery theory and in keeping with a number of relational viewpoints, anxiety and the correlated ideational beliefs are the cornerstone underlying repression and dissociation and are the funda-

mental cause of psychopathology. Systematic research by psychoanalytically informed learning theorists and neuroscientists provide further support for this contention. Many decades ago, Dollard and Miller attempted to create experimental studies that translated Freud's hypotheses about neurosis into quantifiable empirical investigations. They catalogued various kinds of conflicts (e.g., approach-approach, avoidance-avoidance) and described the conflicts that bring patients to treatment as being "approach-avoidance" conflicts. The term "approach" signifies the wish or goal, and "avoidance" signifies the fear or anxiety. In conflicts such as these, they discovered that the avoidance gradient is always steeper than the approach gradient. They demonstrated that in such conflicts, as one moves closer to pursuing one's purpose or gratifying one's wish, the intensity of one's fears become increasingly the predominating motive and the result is avoidance.

Neuroscientists such as Joseph LeDoux have been studying the circuitry of irrational fears in the brain. In studies of the amygdala, using fear-conditioning stimuli, the brain is being found to have a separate memory for fearful stimuli. Stored fearful memories are thought to include archival experiences that we never knew had scared us and that we do not consciously remember. Nonetheless, such memories are indelible. LeDoux and his colleagues have suggested that it is extremely difficult ever to erase any terrifying experience from one's lifelong emotional memory (Hall, 1999). I would infer that Rachel's early bowel pain would be an example of just such a terrifying experience.

I want to touch briefly on the topic of my view of the relationship between wishes and fears. From my perspective, if one helps to alter patients' fears, patients are able to discover a great deal about what it is they want. Maybe they will discover developmental goals as well as primitive wishes. In this view, patients' fears inhibit them from knowing and making choices about pursuing their wishes, desires, and goals. Analytic progress flows from helping patients overcome their pathogenic fears. This process frees patients to bring into focus both their maladaptive, irrational goals as well as their primitive wishes and behaviors. It furthers their ability to integrate and put their wishes into a context.

In my view, primitive, unacceptable wishes do not operate independently. It is my impression that Freud was beginning to hint at these ideas in his signal theory of anxiety, but he did not develop the implications very far. In my reading of "Inhibitions, Symptoms and Anxiety," Freud (1926/1954) did open up the way to psychoanalysts paying more attention to specific experience in order to understand repression. So my view empha-

sizes the contribution of early relationships, on repeating them as transferences, and overcoming them through both insight and corrective emotional experience.

But what about the primitive wishes described in the literature? What was of interest in the case of Rachel is that early on she reported, seemingly with great comfort, her early sexual interest in her father and her penis envy, and yet there was no evidence that this awareness had produced patient change.

I assume that the analysis of primitive wishes can be of inherent value for a number of reasons. Certainly it is of vital importance for a patient's sense of self to have such self-knowledge. But I think that the mutative impact of uncovering primitive wishes may oftentimes be that such an analytic process may serve to reduce important deep-seated fears. For example, in an analysis that enables a patient to lift the repression of death wishes toward loved family members, *pari passu* the patient's pathogenic belief about the magical powers of his or her wishes is disconfirmed. As another example, disturbing but accurate interpretations about unacceptable wishes may serve to alleviate a patient's unconscious anxiety-producing pathogenic beliefs that disagreeable aspects of human experience, theirs or those of loved ones, should not or cannot be faced or mastered. Finally, I think primitive wishes often serve as defenses, compliances, and identifications with family members on whom the patient depended. Some patients may be able to work with the interpretation of such wishes to reduce their compulsion to maintain such compliances and pathogenic identifications and to better regulate their use of such wishes as defenses.

In my work with Rachel I placed an overarching emphasis on analyzing and disconfirming her pathogenic beliefs and expectations. In the course of Rachel's treatment she achieved a good deal of symptom relief. She overcame her bulimia and vaginismus, healed her rectal fissures, and acquired the capacity to experience orgasms routinely when having sexual intercourse. There was also evidence of significant character change. Rachel is no longer inclined to give up her own point of view to compulsively adopt as true the perspective of the other. Moreover, she has not replaced such a pattern of masochistic surrender with a sadistic stance of negating other people's perspectives. Rather, she is characteristically able to stay in touch with her own point of view while paying close attention to that of others. Her increased assertive experience of herself has greatly improved her relationships with her family, friends, and the opposite sex. She has acquired an increased capacity to understand and

tolerate her own characteristic ways of dealing with relationships and with her own anxiety. It is my impression that her "increased clarity of feeling and thought connecting past and present [has enabled her] to achieve greater inner harmony and a sense of outer competence and self-trust in [her] relationships and achievements," in keeping with Johanna K. Tabin's definition of the fundamental goals of psychoanalysis (Tabin, March 10, 2000, personal communication).

In the case of Rachel, the a priori assumption that fundamental change cannot be made without the analysis of primitive sexual and aggressive wishes is challenged. The case raises questions about those theories of analysis that assume that it is necessarily and primarily the interpretation of infantile wishes that leads to deep progress. Except on the basis of such a limited notion about what makes an analysis therapeutic, there is every reason to think that this analysis is going to have an enduring effect and will continue to free Rachel to use her psychological resources to achieve adaptive functioning and life's satisfactions in the realms of work and love.

Conceptualizing Rachel's pathogenic beliefs provided a larger vantage point for identifying the fears that were underlying her symptoms and inhibitions. These pathogenic beliefs were dynamically unconscious, repressed, or otherwise defended against. They were based on childhood experiences and their associated affects, which she also had repressed. Rachel entered treatment unaware of the meaning these experiences had had for her. Her treatment led to her making the kinds of changes that are considered the hallmark of a successful psychoanalysis.

Conclusion

When an analyst interprets a patient's conflicts by focusing on what it is that the patient fears might happen, the patient is likely to perceive the analyst as offering an empathic acceptance and explanation for her or his psychic reality. These explanations help patients become less resistant to self-exploration and more curious to understand their distressing internal realities, transference expectations, symptoms, and conflicts.

Identifying pathogenic beliefs as they are specifically manifested in patients' associations helps patients to acquire greater empathy for themselves. When patients enter treatment, they are usually unaware of the self-fulfilling nature of their pathogenic expectations. It is only as their reconstructed memories emerge combined with the manifestations of their unique transference expectations and reenactments that patients acquire

convictions about the unconscious scripts that have been governing their lives. These scripts are usually derived from their memories of prototypic aversive experiences that now color the feelings and thoughts that compose their subsequent lived experiences. Pathogenic expectations and beliefs provide a road map for understanding not only the ways patients have constructed the destructive meanings of crucially important frightening past experiences, but also how these constructions, usually unconscious, give meaning and to a large extent determine the course of their currently lived experiences of emotional distress.

References

- Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.
- Brenner, C. (1982). *The mind in conflict*. New York: International Universities Press.
- Bush, M. (1986, February). A discussion of Joe Weiss's theory of the psychoanalytic process. *Bulletin #7 of the Mt. Zion Psychotherapy Research Group*, pp. 57–81.
- Freud, S. (1954). Inhibitions, symptoms and anxiety. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 20, 257–269). London: Hogarth Press. (Original work published 1926)
- Freud, S. (1958). Repression. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 143–159). London: Hogarth Press. (Original work published 1915)
- Gassner, S., & Bush, M. (1988). A description and clinical research application of the control-mastery theory. *Clinical Social Work Journal*, 16, 231–242.
- Gassner, S., Sampson, H., Weiss, J., & Brumer, S. (1982). The emergence of warded-off contents. *Psychoanalysis and Contemporary Thought*, 5, 55–75.
- Gassner, S., Sampson, H., Weiss, J., & Brumer, S. (1986). The emergence of warded-off contents. In J. Weiss, H. Sampson, & the Mt. Zion Psychotherapy Research Group (Eds.), *The psychoanalytic process: Theory, clinical observation and empirical testing* (pp. 171–186). New York: Guilford Press.
- Gray, P. (1995). *The ego and the analysis of defense*. New York: Jason Aronson.
- Hall, S. (1999, February 28). Fear itself: What we now know about how it works, how it can be treated and what it tells us about our unconscious. *The New York Times Magazine*, 42–91.
- Horowitz, L. M., Sampson, H., Siegelman, E. Y., Wolfson, A., & Weiss, J. (1975). On the identification of warded-off mental contents: An empirical methodological contribution. *Journal of Abnormal Social Psychology*, 84, 545–55.
- Kris, E. (1947). Problems in clinical research. In *The selected papers of Ernst Kris* (pp. 24–30). New Haven, CT: Yale University Press. (Original work published 1975)
- Kris, E. (1975). The recovery of childhood memories in psychoanalysis. In *The selected papers of Ernst Kris* (pp. 301–340). New Haven, CT: Yale University Press. (Original work published 1956)
- Lichtenberg, J., Lachmann, F., & Fosshage, J. (1992). *Self and motivational systems: Toward a theory of psychoanalytic technique*. Hillsdale, NJ: Analytic Press.

- Lowenstein, R. M. (1954). Some remarks on defenses, autonomous ego and psychoanalytic technique. *International Journal of Psycho-Analysis*, 35, 188–193.
- Rangell, L. (1969). Choice, conflict, and the decision-making function of the ego: A psychoanalytic contribution to decision theory. *International Journal of Psycho-Analysis*, 50, 599–602.
- Richards, A. (1992). The influence of sphincter control and genital sensations on body image and gender identity in women. *Psychoanalytic Quarterly*, 61, 331–352.
- Sampson, H. (1985, March 11). Evidence for unconscious control of repressions and for unconscious testing. *Bulletin #7 of the Mt. Zion Psychotherapy Research Group*.
- Sampson, H. (1986, February). A discussion of Joe Weiss's theory of the psychoanalytic process. *Bulletin #7 of the Mt. Zion Psychotherapy Research Group*, pp. 57–81.
- Sandler, J. (1960). The background of safety. *International Journal of Psycho-Analysis*, 41, 352–356.
- Shilkret, C., Isaacs, M., Drucker, C., & Curtis, J. (1986). The acquisition of insight. In J. Weiss, H. Sampson, & the Mt. Zion Psychotherapy Research Group (Eds.), *The psychoanalytic process: Theory, clinical observation and empirical testing* (pp. 206–217). New York: Guilford Press.
- Sterba, R. F. (1982). *Reminiscences of a Viennese psychologist*. Detroit, MI: Wayne State University Press.
- Stern, D. (1985). *The interpersonal world of the infant*. New York: Basic Books.
- Stolorow, R., & Atwood, G. (1992). *Contexts of being: The intersubjective foundations of psychological life*. Hillsdale, NJ: Analytic Press.
- Tyson, P. (1982). A developmental line of gender identity, gender role and choice of love object. *Journal of the American Psychoanalytical Association*, 30, 61–86.
- Wachtel, P. (1993). *Therapeutic communication: Principles and effective practice*. New York: Guilford Press.
- Weiss, J. (1971). The emergence of new themes: A contribution to the psychoanalytic theory of therapy. *International Journal of Psycho-Analysis*, 52, 459–467.
- Weiss, J. (1993). *How psychotherapy works*. New York: Guilford Press.
- Weiss, J., Sampson, H., & The Mount Zion Psychotherapy Research Group. (1986). *The psychoanalytic process: Theory, clinical observations and empirical testing*. New York: Guilford Press.