Psychotherapy: Theory/Research/Practice/Training
2002, Vol. 39, No. 4, 368–375

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0033-3204/02/$5.00 DOI 10.1037/0033-3204.39.4.368

THE ROLE OF UNCONSCIOUS PATHOGENIC BELIEFS IN AGORAPHOBIA

CYNTHIA J. SHILKRET
South Hadley, Massachusetts

Agoraphobia can severely constrict the life of those who suffer from it. Control-mastery theory is a cognitive psychoanalytic theory that posits that symptoms are caused and maintained by unconscious pathogenic beliefs. Two cases are discussed in detail to support the hypothesis that agoraphobic patients suffer from 2 pathogenic beliefs: The world is a dangerous place that punishes assertiveness and they don't deserve to have a better life. The role of unconscious pathogenic beliefs may serve as a bridge in explaining both the efficacy of cognitive–behavioral therapy as well as the usefulness of longer term psychodynamic treatment in resolving the often significant residual symptoms of these patients.

Agoraphobia is a very frustrating disorder of adulthood that can severely constrict the life of those who suffer from it. Several explanations for its etiology have been put forth over the years, with many researchers in agreement that anxious or overcontrolling parents are one common element in the early history of these patients (Chambless & Goldstein, 1982; Craske, 1999; DeRuiter & Van IJzendoorn, 1992; Shear, Cooper, Klerman, Busch, & Shapiro, 1993). The precipitating event is often thought to be the threat or actual loss of a loved one (Leibowitz & Klein, 1982) or some age-appropriate step toward increased independence in adult life, such as graduation or marriage that the individual feels unable to handle (Compton, 1992). The implication is that these patients are fearful of being independent, and their symptoms, which make them unable to go out into the world alone, perpetuate their dependence. However, researchers have occasionally noted another side to this clinical picture. Shear et al. (1993), in a pilot study that involved detailed interviews with nine agoraphobic patients, noted a common theme of a fear of being trapped in a relationship. Also, Goldstein (1982) noted, "I have been occasionally surprised in the past to note that some clients do quite well, and are sometimes even improved, when a parent dies or leaves the area" (p. 200).

Whatever the etiology, agoraphobia is very difficult to treat. Different approaches to treatment have been studied over the years, with varying degrees of success. Cognitive–behavioral therapy is often recommended, which might include cognitive restructuring (Beck & Emery, 1985), challenging and replacing irrational thoughts, breathing and relaxation training, and exposure (Overholser, 2000). Chambless (1982), in a summary of six different models of treatment, concluded that all six agreed that in vivo exposure was important. This was also supported by a meta-analytic review of the literature conducted by Mattick, Andrews, Hadzi-Pavlovic, and Christensen (1990). However, these studies often reported significant residual disability including continuation of the panic attacks and avoidance of situations that seemed to provoke the attacks (Chambless, 1982; Milrod, 1995; Shear et al., 1993). Also, some researchers have also noted that the more severe the initial symptoms, the

Cynthia J. Shilkret, independent practice, South Hadley, Massachusetts.

I am grateful to Robert Shilkret, PhD, for his careful reading of the manuscript and for his many helpful comments.

Correspondence regarding this article should be addressed to Cynthia J. Shilkret, PhD, 7 Hadley Street, South Hadley, Massachusetts 01075. E-mail: cshilkret@attbi.com

greater the residual disability (Brown & Barlow, 1995; Williams & Falbo, 1996). Craske (1999), in a summary of 13 controlled studies of treatment for agoraphobia, reported that on average only 50% showed substantial improvement at termination. Because most of the published studies reported treatments of less than a year (e.g., in Mattick et al., 1990, the duration of the treatments summarized ranged from 1 week to 28 weeks), there has been a renewed emphasis on longer term approaches to deal with the remaining pathology.

Control-mastery theory (CMT) is a cognitive psychoanalytic theory developed by Joseph Weiss and empirically studied by Weiss, Sampson, and the Mount Zion Psychotherapy Research Group (1986; Weiss, 1993). It assumes that psychopathology originates in unconscious pathogenic beliefs. Unconscious pathogenic beliefs are not wishes, but rather grim, constricting, maladaptive ideas that the individual has formed from traumatic experiences with parents or other loved ones. Some traumas may be powerful chance events, such as the illness or death of a loved one. Because of the children's relative egocentrism, they may assume that the unfortunate event is the result of their own occasional negative feelings toward the loved one. Even lacking such negative or hostile feelings, children may come to believe that they have no right to a better life than a suffering family member (Modell, 1965). Other traumas derive from the ongoing interactions between children and their loved ones. For example, if a particular child's goal is to develop close peer relationships, but that goal happens to be threatening to a needy father who demands that the child be exclusively interested in him, then the child may renounce the goal of developing close peer relationships. That is, the child needs parental help and encouragement to accomplish important developmental goals; the younger the child, the more parental help is needed to accomplish such goals. If such assistance is not forthcoming, the child may infer that the parent does not wish her to develop in that direction. Given the young child's understanding of cause and effect, she may even infer that achieving certain developmental goals would be threatening to her relationship with the parent. She thus may renounce the goal in order to preserve the relationship. Important in this notion of trauma is not simply the reality event itself but also the meaning that the child makes of the experience. Meaning may be distorted because of the child's cognitive immaturity, or it may reflect the parent's actual comments to the child. (See Friedman, 1985, pp. 29–30, for an example of a letter sent by a mother to her anorexic daughter.)

As a result of either type of trauma, a child may then develop a pathogenic belief. Pathogenic beliefs can develop for any normal motive. For example, one child, whose parents worry excessively about any independent behavior on the part of the child, may develop a pathogenic belief that independence is wrong, or even harmful to the relationship with the parents. Another child, whose parents demonstrate that they cannot tolerate the appropriate dependence of the child on the parent, may develop the pathogenic belief that being close to, or depending on anyone, is dangerous (either to the self or to the other person). Whatever the belief, though, it originates in the child's understanding of the real relationship with the parents or other significant caregivers. Also, because the child endows the parents with great authority, the child comes to believe that the way she is treated is the way she deserves to be treated. This makes it extremely difficult to give up the pathogenic belief, because it leaves the child feeling disloyal to the parent. These beliefs are then repressed because of the child's continuing need to preserve a good relationship with the parent(s).

In therapy, patients attempt to disconfirm their pathogenic beliefs by unconsciously testing the therapist to determine if it is safe to recall the traumatic experiences that led to the formation of the pathogenic beliefs. Patients test their therapists in the transference relationship, either by acting as they once did as children (thus, inviting the therapist to act like the traumatizing parent) or by turning passive into active, acting like the traumatizing parent and treating the therapist as the parent treated the child. In either type of test, CMT assumes the patient's unconscious hope is that the therapist will not reenact the previously traumatizing relationship so that the patient will feel safe enough to modify the pathogenic beliefs and ultimately recall the events that led to the formation of the pathogenic beliefs. However, the greater the original trauma, the more pervasive and frightening the resulting pathogenic belief will be. It will then be more difficult for the patient to test the belief because of the dangers predicted. For example, consider the unconscious pathogenic belief: "People will be upset if I am

independent." Other things being equal, it will be easier for a patient whose parent was only mildly bothered by a child's assertiveness to test that belief in the therapy than it will be for a patient whose parent became violent in the face of challenges. Because the second patient unconsciously believes the dangers of assertiveness may be potentially lethal, the safest course is to not be too independent. That patient will test more slowly and tentatively and will require a longer therapy to achieve the goal of disconfirming her pathogenic beliefs.

In agoraphobic patients, one can see the most extreme constriction of a person's independence. This can vary from the individual who is completely housebound, to one who can travel, but only in the company of someone else, to one who can travel alone, but only short distances in familiar neighborhoods. Because of the severity of the symptoms and the difficulty in fully alleviating them, I suggest that the agoraphobic individual will have in her background some experiences that have led to the formation of a pathogenic belief that the world is a dangerous place in which assertiveness will be punished. These experiences might include (but are not limited to) intense and justifiable worry about one's well-being (either because of abuse or neglect) that the child has associated with attempts at assertiveness or intense worry about the well-being of significant caregivers that would leave the child feeling alone and vulnerable. This unconscious belief would then be lived out in the agoraphobic's behavior that there is something frightening about going out into the world.

Additionally, as stated earlier, because the child endows parents with great authority, and so believes she deserves the treatment she has received, the adult patient then develops a second pathogenic belief—that she does not deserve to overcome these dangers and to have a better life. This understanding of agoraphobia suggests a way to integrate the CMT understanding of the formation of pathogenic beliefs with the success reported by some cognitive–behavioral treatments. Cognitive restructuring and in vivo exposure directly challenge the person's pathogenic belief that the world is dangerous. Also, the very act of an authority figure (i.e., the therapist) providing treatment challenges the belief that the person does not deserve to overcome her fears and to have a better life.

However, CMT suggests that behavioral treatment is not the only way to challenge these pathogenic beliefs. The following two cases demonstrate the power of unconscious pathogenic beliefs in understanding agoraphobia and the alleviation of agoraphobic symptoms after the patients became conscious of their beliefs. The cases also illustrate the importance of testing the therapist. The first patient achieved a complete resolution of her symptoms by vigorously testing the therapist. The second patient achieved a partial resolution of her symptoms, in part because her history made it difficult for her to test the therapist as fully as the first patient and in part because the unexpected death of her husband reinforced her belief that she did not deserve to be happy. Both Audrey and Betty had other pathogenic beliefs that were explored in the course of their therapies, but the others did not seem to be central to the understanding of their agoraphobic symptoms.

Case Illustration: Audrey

Audrey,[1] a single woman working as a clerk in a small business, began treatment at the age of 25 with the presenting complaint of multiple phobias, including agoraphobia. She could not fly, could not travel over bridges, and could only get on local buses that made frequent stops so that she could get off when she began to feel panicky. She did work, but was underemployed because she had to work close to where she lived (so that she could walk or take a local bus). She also noted that she was unable to remember anything about her childhood before the age of 16. The history that Audrey did report was sketchy. She was the younger of two children. Her brother was significantly older and left home when Audrey was still quite young. Her parents worked at blue-collar jobs and they fought a great deal. However, Audrey insisted that none of this had been traumatic and that her inability to remember her early life meant that nothing much had happened to her before that time and that her childhood was probably a pretty normal one.

At the end of the first session she agreed to meet the following week. Prior to the next session, she called me to say that she did not know what to do. After her appointment with me she had seen another therapist (she knew about this appointment at the time she saw me, but did not mention it), and she liked that therapist much better than she liked me, so she was not sure which one of us to see. I took this as a test in which she was slightly critical of me and then invited me to reject her. I viewed this as a rejection test because when patients invite therapists to reject them, they often do it in ways that would make it appear reasonable if the therapist did

[1]This case was presented in a different form in Shilkret and Shilkret (1993).

so (e.g., going along with her idea that she should continue in therapy with the therapist she liked better). Therefore, I suggested that she keep our appointment and that we could discuss it then, which she quickly agreed to do. When she came in for her second session, her focus was on how nice the other therapist was—much nicer than I was. When she told this to her friends, they all agreed that she should see the nicer therapist, but for some reason, she just was not sure. (I did ask in what way she felt the other therapist was nicer. She said the other therapist had held the door open for her when she came into the office, while I preceded her into the office and expected her to close the door behind her herself. I took this as confirmation of her worry about rejection and not as a serious complaint that I had not been nice enough to her.)

My initial formulation at that time involved two pathogenic beliefs. One was that the world was a dangerous place that would punish assertiveness. This was based on her fearfulness about venturing out into the world and also on her inability to remember much about her life before the age of 16. Unlike her conscious idea that "nothing much had happened" prior to that time, I assumed that she was repressing traumatic memories about her early life. I also hypothesized that she believed that she did not deserve to be cared for because she was too assertive and critical. I based this on her initial invitation for me to reject her after her mild criticism of me. To demonstrate that I was not bothered by her criticism, I told her during the second session that it was hard for her to have reservations about me and still continue in therapy. She agreed with that and decided to continue seeing me.

After this somewhat unusual beginning, the therapy settled into a predictable routine during which two themes predominated. The first theme was her continuing dissatisfaction with me. Whatever I did was not good enough. I was not helping her; I was cold and uncaring, and so forth. During this time she frequently threatened to quit. She had consultations with other therapists and went to many quasi-therapeutic meetings. She once told me that all her friends were in therapy, and every single one of them was seeing someone who was nicer than I was. This kind of complaining went on for months. However, during that time a second theme started to emerge—her guilt over asserting herself and wanting more in her life. For example, she worried about the men who she dated. Her initial presentation was that she was worried that these men would leave her. However, they all sounded like rather weak and passive men who acted very needy. At one point I suggested that she felt that she was supposed to worry about and care for them and that she felt guilty wanting more from a relationship (despite her often repeated conscious worry that they would leave her). It was striking that her mood immediately lightened.

This pattern continued, with her complaining about my lack of help (to see if I would give up on her), alternating with sessions in which she analyzed her guilt at wanting to be more assertive and not wanting to feel so responsible for others. What was particularly striking was that throughout this time of constant complaining she improved significantly. Her symptoms lessened, and she became more competent in both her work and her personal life. She was no longer phobic about traveling; she decided to take a vacation, and she flew to a resort. She bought some new clothes and in general seemed happier.

Two dramatic vignettes demonstrate the way Audrey's pathogenic beliefs were manifested in treatment: how she tested them in the therapy and what happened when they were disconfirmed.

Vignette 1

After making some progress, Audrey announced that she was moving away because she had decided that all her problems were environmentally caused. She felt they were all due to the stress of living in a big city and that if she moved to a small town in the country she would be fine. After exploring her thoughts and feelings about the move I told her that it was important for her to continue in therapy, and that she should not move at this time. This was followed by two sessions in which she screamed at me that I was ruining her life by keeping her here and making her look at her past. However, after this incident she began to talk for the first time about the responsibility that she always felt for her mother, and she began to remember bits of her history. She talked about the violence in her family, and how her mother seemed unable to protect her and her brother from their father. The mother's response was sometimes to do nothing, and sometimes to run away, but always in a disorganized and futile way that solved nothing because she always came back. This had been going on for as long as the patient could remember, and it left her feeling very frightened and responsible for the well-being of her mother because her mother could not take appropriate responsibility and protect herself or her children. Audrey then went on to discuss something she had not been aware of until then—how she got upset if she thought she could force me to do something because then she felt that I could not protect her. Subsequently, Audrey had another opportunity to move away and decided to wait until she had finished her therapy.

Vignette 2

Audrey had been complaining that I wasn't helping her, when she suddenly started shouting that she hated me and wished that I were dead. She then stopped and said, "I can't believe that doesn't bother you." She said that it would certainly bother her if someone said that to her. I then asked if someone had ever said it to her, and she suddenly remembered an incident from about age 6. She had been arguing with her mother when her mother lost control and put a pillow over her face and started to smother her while saying, "I hate you and I wish you were dead." This was really the culmination of many incidents that led the patient to develop the pathogenic belief that if she were assertive and critical, it would be too much for the other person to handle and could lead to something terrible happening. She then told me something about her family that had made the pathogenic belief all the more compelling for her. Audrey's older brother was always fighting with their parents. The parents could not figure out a way to control him and as a result sent him off to boarding school. He never returned home. When he got old enough he left school and joined the U.S. Army. From Audrey's perspective as a young child, her mother's threat was a real one—her mother could make her disappear as she had her brother. Therefore, Audrey had to give in to the wishes of others in order to preserve herself. Her pathogenic belief that assertiveness led to rejection ruled her life and was an important factor in the development of her symptoms and the ways in which she interacted with others, including me. Her retrieval of the repressed memory of her mother's attempt to smother her made her aware of why assertiveness felt so dangerous for her. She also became aware of her second pathogenic belief: she did not deserve to be cared for. This was a result of her mother's inability to protect her as well as her identification with her mother's inability to protect herself.

Although I had inferred that independence was dangerous from the beginning of therapy, I could not have predicted the specific memories that accounted for the pathogenic beliefs that dominated Audrey's life.

Case Illustration: Betty

Betty was an attractive, although dowdily dressed, 53-year-old married woman who began therapy at the suggestion of her internist because she was still very depressed after the death of her father 8 months before. Although she had been agoraphobic for at least 14 years, she insisted that she did not want therapy for her agoraphobia; she just wanted someone to help her with her current depression so that she did not have to burden her husband or friends.

Betty was the older of two children. She had a brother 4 years younger. Her parents divorced when she was about 6. She described her mother as immature and self-involved and her father as a modest, religious, hard-working man. According to Betty, her father gained custody of both children at the time of the divorce because her mother was "unfit." (It was never clear whether her mother was merely neglectful or possibly psychotic.) At least one time that she could remember, while she was left on her own, she was sexually molested by an older boy. She and her brother were cared for by various female relatives of her father but that arrangement did not last. After a brief time, both children were placed in a local Catholic orphanage. Her father visited every weekend; her mother never did. Her mother remarried several times, and Betty had two half-brothers. Her father also remarried, but he did not bring his children into his new home, even though the daughter of his new wife lived with them. Her father's explanation for this was that he had a very small apartment, he earned very little money, and that Betty and her brother already had a place to live. When she was 13, she went to live with her mother, primarily to be a live-in baby-sitter for her half-brothers. On at least one occasion while living with her mother, one of her mother's boyfriends molested her.

At 18, Betty became a nightclub singer. She loved that life. She loved the attention and the glamour of it. She adopted a glamorous "stage name," that was different from her plain given name. She even took a trip to Hollywood and met a few minor celebrities. Although she never became the star she hoped to be, she was able to support herself. During that time one very traumatic event occurred. When she was 24, her brother was killed in an automobile accident. She was so distraught that she considered giving up her career. She wondered if God was punishing her for pursuing a slightly "shady" career. (Working in these clubs, she often met local criminals, whom she dated.) She loved her career, however, and decided to continue. At 35, she met her current husband when he came to the club to hear her sing. He was like her father—a blue collar, hard-working man of few words. He was a widower, many years older than she was, with grown children.

About 4 years after getting married, Betty had her first panic attack. She could not describe any precipitating events; it just happened "out of the blue." She had some individual and group therapy, which she felt was not helpful. Over the next few years she had more panic attacks until she finally stopped working. With the help of several self-help books and a combination of minor tranquilizers and antidepressants monitored by her internist, her condition stabilized so that she could function, although at a much more constricted level than previously. She was able to go out alone as long as she did not go too far from home. Practically speaking, this meant she could run the household errands, but not much else. She could not travel, could not use elevators, and could not ride in a car on the highway, even if her husband was driving. She also felt claustrophobic in crowds of people and could not go to the grocery store or the mall alone.

After meeting with Betty, I hypothesized that she had the pathogenic belief that the world was a dangerous place in which assertiveness was punished, and that she did not deserve to be cared for and protected. This was based on several factors. One was her history; her world had, indeed, been a dangerous place in which she had been neglected and molested at least twice. Another factor was her thought that her brother's death was her punishment for having an independent, enjoyable life. An additional factor was her insistence that she did not want therapy for her agoraphobia, despite its crippling effect on her life. There was also her history of not getting very much from life, and her acceptance of that without discernable anger. For example, she matter-of-factly described being placed in an orphanage even though she had two living parents and many relatives in the area. Her appearance also was consistent with this view of herself. Although quite attractive, she dressed and wore her hair in a very plain style so as not to call any attention to herself.

Initial Therapy

The theme that ran through Betty's first therapy was her guilt that she was not a good person. This focused initially on her father and her fear that she had not done everything possible to keep him alive. As she came to realize that her prolonged mourning for him was due to her guilt and excessive feelings of responsibility, she began to feel less depressed. She also began to recognize that these feelings applied not just to her father but to her husband as well. She felt that as a good wife she had to be completely devoted to her husband's needs at all times. I suggested that perhaps because of her early experiences of deprivation she had come to believe that she did not deserve very much for herself, and that she was only supposed to serve others. That intervention made a significant impact on her. She then became willing to discuss her agoraphobia in the therapy, although she remained mystified as to what might have precipitated it. Outside the therapy she became a bit more outgoing, and even confronted her husband about a family matter that he had been reluctant to deal with. She then realized that she had recovered from the death of her father. At that point, 18 months after she began therapy, she decided to stop. She felt much less depressed and was somewhat less agoraphobic. All during this first therapy, Betty had tested me by making herself as uninteresting and unworthy of attention as possible (while closely monitoring my reactions to her in order to disconfirm her belief that she was unworthy of therapy). For example, she told me things about herself, but then insisted that they were not important. Then she waited to see how I reacted. Repeatedly, I had to tell her that these things were important. When I did so, almost invariably she would come up with new memories. When I did not tell her these things were important, she often had trouble thinking of anything else to say. Despite my attempts to explore her belief that she did not deserve further therapy, she maintained her position and stopped her sessions.

Second Therapy

Ten months later Betty called, wanting to return to therapy because she was depressed again. She reported several losses

in her husband's family over the intervening months, but the most important event was the news of the impending death of her husband's son from AIDS. We explored her feeling that she was not entitled to be upset and cry (because she had to be strong for others), which brought up memories of her brother's accident and death. She was able to cry and feel some relief that I would help her through this difficult time. Again, she did not want to focus on her agoraphobia, but wanted me to help her with her depression. She planned to continue the therapy until she felt recovered from her stepson's death. Her stepson lived for a year, and during this year of therapy, two themes were interwoven. The first theme was her increasing awareness that her early years had been very traumatic and had resulted in several pathogenic beliefs, including the belief that she did not deserve anything, and that if she got anything for herself, others would resent it or it would be taken away from her. She started her sessions by discussing her worry about asserting herself with her husband and his family, and her fear that they would view her as selfish, unchristian, and so forth if she did not devote herself to her stepson's care. She would then focus on life in the orphanage and how strict the nuns were. No children were allowed individual gifts (if gifts could not be shared they were confiscated), arguing was punished severely, and beatings were frequent. The second theme, as a result of her exploration of the first, was her increased ability to speak up to her husband and her developing ability to leave her house. She made several trips to the local shopping mall and stayed to have lunch alone, which had been impossible for her previously.

After a year, her stepson died and she made no mention of ending therapy. Instead, she focused on the dissatisfactions in her marriage. She described her husband as passive and unemotional; they had few interests in common. For the first time she told me that after they married she had tried to become pregnant for a few years until he finally recalled that he might be sterile as the result of medical treatments years earlier. (It was never clear to me if he consciously withheld this information or if it was just part of his general character style of denial of traumatic events.) Although she felt devastated by this information, she accepted this as God's punishment for two abortions she had had years earlier, and no further discussion of having children ever occurred. (Although she did not mention it, I realized that her panic attacks began shortly after she learned that her husband was sterile.) She then went back to discussing her dissatisfactions with her husband and her wish to be able to travel. I suggested that her panic attacks might serve to keep her from having fun, if she felt she did not deserve any fun. Then, with some embarrassment, she told me her thought, that God gave her these attacks to keep her away from temptation, specifically, the temptation of getting involved with another man. She continued this theme during the next two sessions, discussing her fear of strong emotions. She said that after the previous session she had begun to feel a variety of strong emotions, about which she had mixed feelings. On the one hand, she preferred that to the feelings of deadness and depression she had felt before. On the other hand, she was afraid of the intensity of the feelings, thinking that they might lead her to some sort of action that would hurt her husband. The following week she reported that she and her husband had gone to the movies, something that she had been unable to do for 12 years. She also decided to take a trip to New York City. Never having been there, she became very involved in researching the details of the trip, the best way to travel, where to eat, what to see, and so forth. She ultimately decided on a one-day train trip as a "trial run." After 2 months of planning, she and her husband went and she had a wonderful time. She returned home ecstatic and decided to go again. With her new ability to feel happy and enjoy her life, she then began to experience more deeply the true sadness of her early life. For the first time she wept openly thinking of the death of her brother. She also spontaneously admitted that she would not have married her husband if she had known that he was sterile. She spent many sessions discussing "mixed feelings." It was a new idea to her that she could have both strong positive and negative feelings about someone. Until that time she had been afraid to have consciously negative feelings about anyone close to her, for fear that they would be hurt or leave her.

Around this time, Betty's husband was diagnosed with terminal cancer. She spent the next year caring for him until he died. She continued in therapy for a brief time after his death, but then decided to terminate therapy. Attempts to discuss the meaning of her decision and her pathogenic belief that she was not entitled to make further progress after her husband's death did not change her mind. At termination, she was able to drive and go to the mall on her own, but she had become somewhat more phobic again and felt that she could not take any more trips like her train trip to New York.

Discussion

Both Audrey and Betty demonstrate the crippling effects of their unconscious pathogenic belief that the world is a dangerous place in which assertiveness would be severely punished. Both women minimized and repressed the danger in their early lives. The length of time required for each one to become aware of her pathogenic beliefs speaks to the tenaciousness of these unconscious ideas. Audrey insisted that her early exposure to violence at home was not traumatic, yet it took her 4 years to be able to recall her mother's brief assault on her. Betty talked matter-of-factly about beatings in the orphanage and expressed astonishment when I suggested that she had had an extremely difficult early life. The idea that this belief about the dangerousness of the world is not conscious is also supported by research of Williams, Kinney, Harap, and Liebmann (1997). They found that agoraphobic patients, when put into scary situations (either driving or being in a dark room), consciously focused on their anxiety and somatic concerns. They did not consciously think of perceived danger, current or future.

Both women were also completely unaware that they were living in compliance with another powerful pathogenic belief that they did not deserve more from life. Their lives were ruled, albeit unconsciously, by the idea that because they had been treated this way by the important people in their lives, this was what they deserved. This

second belief made it very hard for them to explore the experiences in their early life because they would then feel critical of, and disloyal to, their parents. For example, throughout the early months of her therapy, Betty maintained that her father was "perfect." She was unaware that she believed that she was bad and thus deserved whatever happened to her. (Because parents are so important to children, when there is a conflict, children tend to believe that the parents are right and they must be wrong. Beres, 1958, demonstrated this in a study of children placed in foster homes. All the children assumed they had been sent away as a punishment for something bad they had done, and that they deserved the punishment.) For these patients, even the crucial beliefs that the world is a dangerous place that punishes assertiveness and that they did not deserve a better life had to be made case specific and could not be interpreted in a rote or generic manner. For example, early in Betty's therapy, before I knew about her attempts to have children, I wondered if her symptoms were precipitated by her possible guilt over success because she told me that everything had been going very well at that point in her life. She agreed that the idea made sense and it fit with her general view of herself, but nothing changed. It was only after she revealed the additional material about her husband's sterility and a more specific interpretation could be made (because some things had gone well, she dared to want even more, including possible motherhood) that her symptoms dramatically diminished.

Both Audrey and Betty were unconsciously afraid that assertiveness (i.e., trying to have a better life) would lead to punishment. But they used different strategies to try to disconfirm their pathogenic beliefs. Audrey tested me from the beginning to see if I could tolerate her assertiveness and criticism. Betty's tests were much more muted. She rarely asserted herself in the therapy and had to be encouraged to express her opinions. This difference may be due to the differences in their histories. In Audrey's family, fighting (i.e., extreme assertiveness) was the norm, and this may have given her some unconscious hope that I could tolerate her asserting herself. However, Betty's background was much bleaker, starting with her early neglect even prior to her placement in the orphanage. This may have made asserting herself much too dangerous. (This difference in the degree of hopefulness is probably also reflected in Audrey's beginning therapy in her 20s, soon after she became agoraphobic, whereas Betty did not feel she deserved therapy for her agoraphobia even after 14 years.) Betty's less hopeful attitude was then unfortunately compounded by the illness and subsequent death of her husband during her therapy. This reinforced her belief that asserting oneself does lead to harm and so she could not allow herself to fully free herself from her symptoms.

The role of these unconscious pathogenic beliefs may help to explain some of the disparate findings in the treatment of agoraphobia. For example, while agoraphobic patients are generally viewed as fearful of independence, Goldstein (1982) observed that patients sometimes improved when a parent died or moved away. One can speculate that these patients want to be independent, but they have inferred from the behavior of their overcontrolling parent that the parent does not want them to assert themselves and so they unconsciously comply. When the parent is not around, it may give some patients the latitude to test out their beliefs. If the parent has moved away, the patient may learn that her assertiveness does not hurt the parent; if the parent has died, the patient may feel that she can no longer harm the parent.

The role of unconscious pathogenic beliefs may help to explain the success of cognitive approaches to the treatment of agoraphobia because cognitive therapies challenge the patient's pathogenic beliefs, which may also help explain the reports of significant residual disability (Chambless, 1982; Milrod, 1995; Shear et al., 1993). As long as the patient remains unaware of the pathogenic belief "I deserve to suffer" it would be difficult to feel entitled to a complete alleviation of symptoms.

These two unconscious pathogenic beliefs (the world is a dangerous place in which assertiveness will be punished and the person deserves to suffer) may also play a role in other severely constricting symptoms that keep an individual from being active in the world. For example, another patient, Mary, began therapy with debilitating fibromyalgia and chronic fatigue syndrome that left her with no energy to do anything besides function minimally at her job. After a 5-year therapy during which she discussed her profound neglect by both parents, her sexual abuse by a neighbor that occurred because of the neglect, and her previously unconscious belief that this

was all she deserved from life, she became increasingly active both at work and in the rest of her life, and she even completed a marathon. It may be that other symptoms that severely limit the person's ability to function in the world (such as multiple chemical sensitivities without an organic basis) may also share these pathogenic beliefs.[2] More detailed studies of patients exhibiting these types of severely constricting symptoms would need to be carried out to determine if these pathologies do share pathogenic beliefs similar to those of agoraphobic patients: the world is a dangerous place in which assertiveness will be punished and the person deserves to suffer.

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[2]I thank the anonymous reviewer who suggested this possibility.

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