THE EFFECTS OF SHAME, GUILT, AND THE NEGATIVE REACTION IN BRIEF DYNAMIC PSYCHOTHERAPY

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This study shows that patient levels of shame and guilt correlate significantly with the outcome of brief dynamic psychotherapy. Negative reaction refers to unconscious shame, guilt, and a need for punishment when seen in psychotherapy. The Therapy Shame and Guilt Scale was developed to assess transcripts of brief psychotherapies with 35 men and women aged 20 to 80. Two judges rated sessions 1, 5, 8 and 14 on the Therapy Shame and Guilt Scale; separate judges rated sessions 1 and 8 on the Vanderbilt Negative Indicators Scale (VNIS). Overall, the strongest predictor was the guilt subscale, which correlated significantly with outcome at all five sessions and predicted outcome more strongly than the shame subscale or the VNIS scale.

Shame and guilt have long been recognized as prominent resistances to psychoanalysis. However, empirical studies have been scarce. Instead, psychotherapy research has focused more on factors

that enhance psychotherapy than those that impede it.

A few studies have investigated negative therapeutic results empirically. Strupp et al. (1977) developed the Vanderbilt Negative Indicators Scale, for example. Its five subscales include patient qualities, therapist personal qualities, and errors in therapeutic technique. Strupp et al. found that the VNIS could differentiate patients with highly successful outcomes from those with poor outcomes. Janet Sandell Sachs (1983) applied the VNIS to a larger sample and found that although Errors in Technique was the strongest predictor of outcome, the patient qualities subscale was also significantly related to outcome.

Previous empirical studies by the Vanderbilt Group have not adequately delineated which patient qualities are most significant. Although patient self-derogation is an important item on Sachs' scale, its specific effect on outcome is not emphasized. We hypothesized that patients' degree of shame and guilt would be significant predictors of therapy outcome. Since there were no existing measures that assess shame and guilt, a patient shame and guilt scale was developed. We then sought to determine whether this new scale could predict therapeutic outcome as well as—or better than—the VNIS.

Background

Recent literature from the Mount Zion Research Group in San Francisco suggests that guilt (both conscious and unconscious) plays a major role in psychopathology and in psychotherapy (Weiss et al., 1986). Historically, the role of unconscious guilt in psychopathology has been widely acknowledged by psychoanalysts who often observe the following clinical event: A patient has made some progress and the therapist is encouraged. Then, following an intervention(s) that ordinarily inspires others to break through the issue at hand, the patient instead regresses dramatically. Freud

(1923) referred to this unexpected turn of events as the *negative therapeutic reaction*. A special kind of resistance to treatment, it is rooted in unconscious guilt and a need for punishment. Such patients exhibit an inability to endure pleasure and persistently cling to suffering or illness. Treatment and recovery increase their sense of guilt, whereas illness appeases their need for punishment. Hence they resist interventions that ordinarily produce relief.

The negative therapeutic reaction is defined here as the worsening of symptoms following therapeutic interventions that would ordinarily produce a lessening of of symptoms, a relief from suffering, a mastery of impulse life, and an increase in insight. The essence of the reaction is that the patient becomes worse when he or she might be expected to improve. The reaction thus does not describe patients who simply resent the therapist's interpretation, clarification, or confrontation.

Shame refers to an experience of shortcoming that arises when an ego-ideal goal is not met. The essential elements of shame are experienced as inferiority, failure, and the fear of abandonment. This results from faulty ego-ideal development and a relatively low level of ego functioning. Shame may also take more mature forms and be integrated in the overall functioning of the personality.

Traditionally, *Guilt* has been conceptualized as a painful tension generated when the barriers of the superego are transgressed by aggressive or sexual impulses. The individual's sense of punishment is governed by the Law of Talion ("an eye for an eye"), which may produce castration anxiety. More recently, guilt has been conceptualized in broader terms. According to this more recent perspective, guilt may stem from an innate concern for the pain of one's parents, assuming the responsibility for this pain and connecting it with one's pursuit of normal developmental goals (Bush, 1989; Friedman, 1985; Weiss et al., 1986). Many theorists share the notion that guilt accompanies the unconscious fantasy that improvement will have devastating consequences for both the client and the mother (Asch, 1976; Loewald, 1972; Modell, 1965, 1983; Olinick, 1964; Vallenstein, 1973; Weiss et al., 1986). In cases of severe superego pathology, therapist interventions which might normally encourage the ego to assert its independence from the punitive superego, the client's unconscious negative expectations—derived from early object experiences—may cause negative reactions.

Lewis (1971) analyzed the relationship of shame and guilt to symptom formation in neurosis. She established several standards for differentiating shame and guilt which have been helpful in constructing the current scale. She distinguished between shame and guilt experiences in terms of their relatedness to self and others. When feeling shame, the patient sees himself or herself as a weak, helpless, fragmented, shy, and injured person in relation to a powerful, ridiculing, and hurtful other. The self is experienced as the object of scorn, contempt, humiliation, and ridicule. When feeling guilt, the self is both the source and the object of the negative valuation. Accordingly, the patient has a powerful self-image as a strong and hurtful person in relation to a dependent, vulnerable, weak, injured, and suffering other. The self functions in an omnipotently responsible way toward others and is occupied with self-blame, adverse self-criticism, and moral disapproval.

Using the concepts outlined above, this study's scale was designed to assess shame and guilt from the transcripts of brief psychotherapies. We hypothesized that patient levels of shame and guilt will correlate significantly with outcome in brief psychotherapy.

Method

Subjects

Patients. The subjects in this study were 35 men and women between the ages of 20 and 80 (mean age 55.5) who participated in a study of brief psychotherapy at Mount Zion Hospital, San Francisco. Prior to therapy, all patients were evaluated by an independent clinical evaluator and met the following minimal acceptance criteria: 1) a history of positive interpersonal relationships; 2) no evidence of psychosis, organic brain syndrome, or mental deficiency; 3) no evidence of serious substance abuse; and 4) no evidence of suicidal or homicidal potential. Although they differed in presenting complaints, all patients in this sample were diagnosed (on the basis of the clinical interview) as suffering from neurotic or character disorders or both.

Subjects received 16 weekly sessions of psychodynamically oriented psychotherapy. All sessions lasted 45 minutes, and all were audiotaped. Each subject received intake and termination interviews by an independent clinical evaluator.

Therapists. A total of 17 therapists (11 male

and 6 female) were employed in this study. Their ages ranged from 31 to 75. Each had at least 5 years' postdoctoral experience, including some training in brief dynamic psychotherapy. Most saw 2 patients; none saw more than 3. All sessions took place at Mount Zion Hospital.

Raters. Two raters who were unfamiliar with these therapists and patients rated shame and guilt. One judge was male, one female, and both held PhDs in clinical psychology. Both were trained in a psychodynamic framework.

Measures

Outcome Measures. Therapeutic change was assessed by the following four measures:

1. At the beginning of treatment, the patient, the independent evaluator, and the therapist independently listed the patient's three target complaints, their severity, and the therapeutic goals (Battle et al., 1966). Immediately after termination of therapy, ratings were made of the changes in severity of the three target complaints and of the degree to which the pretherapy goals were attained.

2. The Symptom Check List (SCL 90–R) is a multidimensional self-report inventory of symptoms, which the patient completed pretherapy and posttherapy (Derogatis et al., 1974; Waskow & Parloff, 1975).

3. The Global Assessment Scale (GAS), which the therapist and the independent evaluator each completed pre- and posttherapy, provides an overall rating of the patient's level of functioning on a continuum of psychological health (Endicott et al., 1976).

4. The Overall Change Rating, which was completed by the patient, therapist, and independent evaluator at the end of therapy, describes the overall degree of improvement or deterioration since the beginning of therapy (Waskow & Parloff, 1975).

Therapy Shame and Guilt Scale. The Therapy Shame and Guilt Scale was constructed to assess patients' degree of shame and guilt verbalized in psychotherapy sessions. The instrument includes 33 items, all of which singly or in combination are hypothesized to be characteristics of shame and guilt. This scale is based in part on an evaluation of transcripts that included patient/therapist exchanges about shame and guilt and on existing psychoanalytic literature. Each of the 33 items was rated on a 6-point (0 to 5) Likert scale.

The scale includes 17 shame categories and 16 guilt categories (see Table 1).

Most categories are divided into specific items

which are defined according to whether the patient reports the experience as relating to self (a), therapist or others (b), or whether the patient views the therapist or others as the object or source of shame and guilt (c).

The Vanderbilt Negative Indicators Scale. To assess the concurrent validity of the Therapy Shame and Guilt Scale, sessions 1 and 8 were rated using the Vanderbilt Negative Indicators Scale (VNIS), which is designed to assess characteristics in the therapeutic process that relate negatively to outcome (Strupp et al., 1977). For practical purposes of obtaining concurrent validation, the VNIS version used in this study was shortened to obtain patient qualities, patient–therapist interaction, and global session ratings. As with the Therapy Shame and Guilt Scale, the unit of analysis is the whole session.

Procedure

The Therapy Shame and Guilt Scale was pilot tested to ensure adequate reliabilities. By the time of the actual study, the judges had spent approximately 25 hours in training to familiarize themselves with the scale and the rating task. Transcripts of sessions 1, 5, 8, 11, and 14 were presented in random sequence. The judges were unaware of which session they were rating and of the therapeutic outcome. Each therapy session was divided into nine 5-minute segments, and judges independently rated each 5-minute segment.

Results

Process Measures

Interjudge Reliabilities. For the 33 items of the Therapy Shame and Guilt Scale, interjudge reliabilities by use of the Pearson product-moment correlation were quite high, ranging from $r = .60$ to .97. Reliabilities were relatively low on only two items and were still acceptable ($r = .60, .73$). For the VNIS, interjudge correlation was generally quite high, with the exception of item 21 (dull interaction) (median $r = .15$). Alpha reliabilities ranged from .45 for item 21 to .98 for item 10 (self-rejection).

Shame and Guilt Subscales. Analysis of the internal consistency of the 17 shame items yielded an acceptable alpha reliability of .78; of the 16 guilt items, an acceptable alpha of .79.

An exploratory factor analysis determined the extent to which the shame and guilt items would separate into two clear factors. Using squared multiple correlations on the diagonal and Varimax

TABLE 1. Factor Analyses of Shame and Guilt Ratings for Middle Session

	Shame Item	Factors	
		I	II
Ridicule a	1	.75	−.05
Ridicule b	2	.07	.08
Ridicule c	3	.75	.03
Humiliated a	4	.81	−.05
Humiliated b	5	.18	.25
Humiliated c	6	.81	.10
Fragmentation a	7	.50	.10
Fragmentation b	8	−.17	.74
Fragmentation c	9	−.07	.73
Childish a	10	.47	.24
Childish b	11	−.03	.13
Childish c	12	.24	−.04
Admiration a	13	.60	−.19
Admiration b	14	−.00	.09
Admiration c	15	.61	−.00
Negative attitudes	16	.44	.37
Defenses	17	.13	−.22

	Guilt Item	Factors	
Blame a	18	.41	−.01
Blame b	19	.06	−.11
Blame c	20	−.11	.62
Responsibility a	21	−.17	.49
Responsibility b	22	.09	.21
Responsibility c	23	−.15	.73
Criticism a	24	.45	.00
Criticism b	25	−.11	−.19
Criticism c	26	−.07	.92
Survival guilt a	27	.17	−.00
Survival guilt b	28	−.00	−.02
Survival guilt c	29	−.15	.94
Avoidance of pleasure	30	.32	−.12
Avoidance of therapeutic success	31	.27	.46
Negative attitudes	32	.26	.32
Defenses	33	.26	.05

rotation, principal components analysis was performed on the 33 items and was pre-set to two factors. This analysis was conducted separately for the ratings from each session. The results of the analyses varied somewhat by session, but results for the middle sessions are illustrative, and are shown in Table 1. The shame items tended to form one factor and the guilt items another, although a few items loaded on neither factor. For purposes of the present study, however, the a priori shame and guilt subscales are of adequate reliability and were used in subsequent analyses. The median correlation of the guilt and shame subscales across the 5 sessions sampled was .37, ranging from .29 for session 11 to .57 for session 1. Mean shame scores ranged from .56 to 25.0 and guilt scores from 1.38 to 28.72 (see Table 2).

VNIS Subscales. The Vanderbilt items were reduced to the three standard VNIS subscales from which they were drawn: the patient scale, the patient–therapist interaction scale, and the global session scale. Overall, internal reliabilities for the subscales were higher for session 8 than for session 1. The alpha reliability of the 17 patient subscale items was .64 for session 1 and .78 for session

TABLE 2. Means, Standard Deviations, and Ranges on Process Measures

	N	X̄	SD	Range
Shame session 1	35	10.8563	5.7458	2.46 to 23.83
Shame session 5	34	10.2247	5.5491	2.86 to 22.24
Shame session 8	35	9.2320	4.6276	.56 to 24.95
Shame session 11	34	9.6618	4.3118	1.58 to 17.90
Shame session 14	34	9.0650	4.8798	2.61 to 23.21
Guilt session 1	35	7.0189	4.3460	1.38 to 17.99
Guilt session 5	34	9.2976	5.7214	3.00 to 28.72
Guilt session 8	35	6.8677	3.4662	1.67 to 15.61
Guilt session 11	34	7.7374	4.5350	1.84 to 23.16
Guilt session 14	34	7.2650	4.0963	2.18 to 18.38
Van patient mean	35	9.2917	4.5318	3.85 to 24.45
Van interaction mean	35	1.0551	1.1789	0.00 to 4.44
Van global mean	35	3.3861	3.1652	0.00 to 11.67

8. The alpha reliability of the global session subscale items was .61 for session 1 and .73 for session 8. The two items forming the patient–therapist interaction subscale were also of acceptable reliability, correlating .43 for session 1 and .54 for session 8. Correlations between the patient and the interaction subscales were .64 and .72 for sessions 1 and 8, respectively; between the patient and the global session subscales .67 and .62; and between the interaction and the global subscales .72 and .62. Interjudge reliabilities for the VNIS scale ranged from .45 to .98 with an average coefficient alpha of .84.

Relation of Shame and Guilt Items to the VNIS. The Therapy Shame and Guilt Scale, it will be recalled, was constructed because the Vanderbilt items did not appear to cover the domain of shame and guilt sufficiently. Only one item on the Vanderbilt, self-rejection (item 10), comes close to the concepts of shame and guilt; this study needed additional items to more sensitively reflect shame and guilt.

Correlations between the VNIS and shame and guilt items tended to support this impression. For both sessions, the VNIS self-rejection item showed the highest number of significant correlations with the shame and guilt items. Twelve of the 33 correlations with shame and guilt items were significant for session 1, and 9 of the 33 for session 8. The next highest numbers of significant correlations were 8 for session 1 (Vanderbilt item 3, passivity) and 7 for session 2 (Vanderbilt item 2, responsibility).

Prior analysis of the items clearly indicates that the shame and guilt items assess somewhat different phenomena than do the Vanderbilt items. Session 1 showed little overlap between the shame and guilt subscales and the VNIS subscales (see Table 3). For session 8, the relationships were somewhat higher, particularly for the guilt subscale (Table 3).

Outcome Measures

Pre- and posttherapy outcome measures were obtained from three sources: the patient, the therapist, and the independent evaluator. Except for overall change, which was rated only after therapy, all measures were obtained both pre- and posttherapy. Outcome measures obtained from the *patient* included the SCL-90 (total score), target complaints 1 and 2, and a rating of overall change. Ratings obtained from both the *therapist* and the *evaluator* were the GAS, target complaints 1 and 2, and a rating of overall change. Scores on the SCL-90 and target complaints were reversed, so that for all outcome measures, high scores indicated improvement.

Reduction of Outcome Measures. Factor analysis was used to determine how to combine the posttherapy outcome measures. A principal components analysis was employed, using squared multiple correlations on the diagonal and Varimax rotation. Four factors were obtained: 1) patient SCL-90 total; 2) patient ratings (patient target complaints and overall change); 3) therapist ratings (GAS, target complaints overall change); and 4) evaluator

TABLE 3. Incorrelation of Shame and Guilt Subscales with Vanderbilt Subscales for Sessions 1 and 8

	Shame	Guilt
Session 1		
Vanpatient	−.00	.32
Vaninteraction	.03	.19
Vanglobal	−.11	.09
Session 8		
Vanpatient	.18	.42*
Vaninteraction	.19	.51**
Vanglobal	.28	.41*

$N = 34$.
* $p \leq .05$.
** $p \leq .01$; all values are two-tailed.

ratings (GAS, target complaints overall change). Composites were formed using unit weighting of standard scores.

Relation of Process and Outcome Measures

Correlations between Process and Outcome Measures. Table 4 shows the zero-order corre-lations between process and outcome measures. Correlations between *shame and guilt* ratings and outcome measures are in all cases negative. This is consistent with the hypothesis that high levels of shame and guilt are associated with poor out-come. The correlations are consistently higher for guilt than for shame.

Correlations between the *Vanderbilt subscales* and the outcome measures are in most cases neg-ative but are generally not as high as the correlations between shame and guilt and outcome. Of the 24 correlations between the VNIS subscales and var-ious outcome measures, 7 are statistically signif-icant at the $p < .05$ level (two-tailed). This com-pares with 17 out of 20 statistically significant correlations for guilt and outcome, and 6 out of 20 for shame and outcome.

Hierarchical Multiple Regressions. Two hier-archical multiple regressions were conducted for each of the four outcome measures. On the first step of each regression, the relevant pretherapy measures were entered for the particular outcome measure. Then, for one regression, the shame and guilt measures were entered on steps 2 and 3, followed by the Vanderbilt ratings on step 4. For the other regressions, the Vanderbilt ratings were entered on step 2, followed by the shame and

TABLE 4. Zero-Order Correlations of Process and Outcome Measures

	1 Patient SCL 90 Total	Patient Ratings	Therapist Ratings[1]	Evaluator Ratings
Shame 1	−40*	−09	−08	−12
Shame 5	−32	−32	−28	−32
Shame 8	−21	−31	−53***	−43*
Shame 11	−46**	−45**	−15	−48**
Shame 14	−26	−12	−14	−30
Guilt 1	−57***	−37*	−40*	−40*
Guilt 5	−46**	−45**	−34*	−43*
Guilt 8	−58***	−61***	−31	−56***
Guilt 11	−34*	−31	−27	−42**
Guilt 14	−43**	−39*	−47**	−55***
Vanpt 1	−17	−32	−39*	−31
Vanpt 8	−06	−17	−39	−42*
Vanint 1	−25	−38*	−07	−24
Vanint 8	−12	−29	−15	−42*
Vanglob 1	−00	−22*	−34*	−30
Vanglob 8	−23	−35	−25	−55***

* $p \leq .05$, two-tailed.
** $p \leq .01$, two-tailed.
*** $p \leq .001$, two-tailed.
[1] Scores on Patient SCL 90 were reversed so that high scores indicate positive outcome.

guilt ratings on steps 3 and 4. This strategy allowed us to determine the extent to which the shame and guilt measures predicted outcome beyond the contribution of pretherapy levels, as well as the contribution of shame and guilt relative to the VNIS as a predictor of each type of outcome.

In all of the regression analyses, the guilt subscale was the most powerful predictor of outcome ($p < .01$), regardless of whether it was entered before or after the Vanderbilt. The shame scale, however, did not contribute significantly to the prediction of outcome in any of the regression analyses. The VNIS scores where predictive in only one of the analyses: the therapist ratings of outcome ($p < .05$).

The findings, therefore, are clear: the guilt subscale is the most powerful process predictor of outcome in the present data set.

Discussion

This study demonstrated that patient levels of shame and guilt—and most strikingly patient's guilt—are associated with therapeutic outcome. These results underline the importance of shame and guilt in the therapeutic process and the need to investigate these patient qualities further. Although other measures in the field such as the VNIS have focused on indicators for negative therapeutic outcome, they have not sufficiently taken into account the patient variables of shame and guilt. The current study presents a scale for measuring shame and guilt and shows that the scale is a better predictor of outcome than the VNIS.

As expected, the major point of overlap between the Therapy Shame and Guilt Scale and the VNIS is in item 10 of the Vanderbilt (self-rejection), which has the most significant correlation with the shame and guilt items. Described as a patient's expression of shame, self-hatred, or a sense of failure in excess of what the situation would suggest, this item clearly captures some essential features of the Therapy Shame and Guilt Scale. Two other Vanderbilt items which where correlated with the Therapy Shame and Guilt Scale were item 2 (failure to take responsibility for problems) and item 3 (passivity in the therapeutic interaction). Kirtner & Cartwright (1958) and Saltzman et al. (1976) found that patients who failed to take responsibility for their problems did not make major changes in therapy. The failure to take responsibility is reflected in the projective categories of both the shame and guilt subscales. Finally, Mar-

ziali et al. (1979) reported that patients who were passive or withdrawn had poor outcomes in therapy. Both a passive-dependent attitude and a failure to take responsibility for problems may indeed be part of a more complex constellation of factors undermining therapy.

One essential finding of this study was that patients with high ratings on shame and guilt did not make substantive gains in therapy. Patients who exhibited poor treatment outcomes on all outcome measures exhibited significantly higher levels of shame and guilt in every session than did a contrasting good-outcome group. This is consistent with the idea that the negative reaction stems from intrapsychic imbalances and superego pathology within the patient (Sandler et al., 1970) rather than representing a sole function of the therapeutic relationship.

As expected, another major finding was that guilt was a consistently better predictor of outcome than was shame or the VNIS. A number of psychoanalytic writers (Bush, 1989; Friedman, 1985; Modell, 1965; Weiss et al., 1986) have noted that guilt plays a prominent role in the development and maintenance of psychopathology. The findings presented here provide empirical support for this position.

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