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The Role of Guilt in Obsessions and Compulsions

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Abstract

Clinical data and recent theorizing suggest that guilt is a significant factor in OCD. This study empirically evaluates the importance of interpersonal guilt in O-C symptoms. One hundred and sixteen college students completed the Padua Inventory, the Interpersonal Guilt Questionnaire-67, and the Beck Depression Inventory-II. Subjects also completed an Early Life Experiences Scale in order to investigate the relationship between O-C symptoms and childhood experiences. Depression, guilt, and negative childhood experiences all correlated significantly with most O-C symptoms. A multiple regression analysis showed that while depression accounted for more of the variance than did guilt, guilt was still a significant predictor of many O-C symptoms after controlling for depression. While this study needs to be replicated with a clinical population, the results are discussed in terms of their implications for treatment.

Obsessions are repetitive, intrusive, and unwanted ideas, thoughts, impulses or images. Common obsessions include thoughts of harming others or causing accidents to occur, a need to do things perfectly, an unreasonable concern with becoming contaminated, and offensive sexual or religious ideas. Compulsions are repetitive behaviors or mental acts that serve to reduce distress by decreasing the likelihood that a dreaded event will occur. A person who fears contamination, for example, may reduce or neutralize this fear through excessive hand washing. Other common compulsions include counting, checking, ordering, and demanding assurances.

Obsessions and/or compulsions are the diagnostic criteria for obsessive-compulsive disorder (OCD). OCD is a disabling disorder that often begins in adolescence and persists throughout a person's life. Epidemiological studies suggest that the lifetime prevalence of classic OCD may be as high as 2.5 percent of the population – making it a more common disorder than schizophrenia, bipolar disorder, or panic disorder (Antony, Downie, & Swinson, 1998; NIMH, 1996). With inclusion of the obsessive-compulsive spectrum disorders, it is estimated that more than ten percent of the population is affected (Hollander & Benzaquen, 1997; Ratey & Johnson, 1997). Furthermore, it has been noted that the average time between onset of OCD symptoms and appropriate treatment is seventeen years (Hollander & Wong, 1995).

The studies of Rachman and de Silva (1978) and Salkovskis and Harrison (1984) indicate that most people seem to experience a phenomenon similar to the abnormal obsessions experienced by persons with OCD. The difference between normal and abnormal obsessions lies in how disturbing, frequent, and easily dismissed the obsessions are. The fact that there exists a normal analogue of clinical obsessions makes it possible to use a non-clinical sample in OCD research.

Recent research on OCD has focused on responsibility and, to a lesser extent, guilt (Niler & Beck, 1989; Rachman, 1993; Rachman, Thordarson, Shafran, & Woody, 1995; Reynolds & Salkovskis, 1991; Savoie, 1996) in part due to Salkovskis' formulation of a cognitive model for OCD that emphasizes the role of personal responsibility and guilt in explaining obsessive-compulsive symptoms (Salkovskis, 1985, 1989). According to this model, intrusive thoughts become problematic as a result of negative automatic thoughts that are linked to an inflated belief

that one is responsible for causing harm to oneself or others (e.g. "By touching my daughter I may have contaminated her and given her a horrible disease"). Such feelings of excessive responsibility illicit strong feelings of guilt (e.g. "If my daughter gets sick, it will be all my fault"). Compulsions serve to neutralize beliefs about responsibility and feelings of guilt by reducing the possibility of being responsible for harm to oneself or others (e.g. "By washing my hands and not touching my daughter, I can prevent my daughter from getting sick").

Niler and Beck (1989) in their study of seventy-six normal subjects found that self-reported guilt was the best predictor of negative intrusive thoughts and impulses – better than self-reported depression or anxiety. In a replication of this study with 169 normal subjects, Reynolds and Salkovskis (1991) were unable to validate these findings. Reynolds and Salkovskis report that once other variables are considered, guilt is not an independent predictor of the frequency of negative intrusive thoughts and impulses. Rather, depression and anxiety are better predictors.

In a later study of a non-clinical population, Freeston, Ladouceur, Thibodeau, and Gagnon (1992) found five factors in cognitive intrusions. The third factor, which consisted of responsibility, guilt, and disapproval, was the best predictor of compulsive activity scores. There have been two other studies involving clinical samples. Shafran, Watkins, and Charman (1996) compared subjects with OCD to normal adults and found that subjects with OCD experienced more guilt than normal subjects and that trait guilt was the only significant predictor of obsessions and compulsions in the OCD group. In another study, OCD subjects were compared to anxious subjects and it was found that the OCD subjects were not more guilty than the anxious subjects. However guilt was positively correlated with the severity of obsessive compulsive symptoms in the OCD subjects (Steketee, Quay, & White, 1991).

In comparing different types of obsessive-compulsive phenomena, Rachman (1993) also emphasizes the significance of an exaggerated sense of responsibility and feelings of guilt – particularly in compulsive checking and obsessional thinking. When, for example, subjects with checking compulsions are relieved of a sense of responsibility for certain acts, their urge to check decreases (Lopatka & Rachman, 1995; Rachman & Hodgson, 1980). Rachman writes that because

"an inflated sense of responsibility is a common characteristic of compulsive checkers (and doubters). . . it follows that checkers should also experience more intense and more frequent feelings of guilt. . ." (Rachman, 1993, p. 153).

Additional research investigating the relationship between guilt, shame, and psychological problems was able to demonstrate significant correlations between obsessive-compulsive symptoms and various measures of guilt, including omnipotence guilt and survivor (outperforming) guilt (O'Connor, Berry, & Weiss, 1999). Weiss (1986, 1993) has suggested that people with OCD symptoms suffer from pathogenic beliefs warning them that if they pursue certain normal, desirable goals, they will harm loved ones. These beliefs give rise to both conscious and unconscious guilt and inhibitions (Bush, 1989; Weiss, 1983, 1993; Weiss, Sampson & The Mount Zion Research Group, 1986). In this conceptualization of guilt, it is assumed that both the anticipation of pursuing normal goals, as well as the actual pursuit of goals, may give rise to feelings of guilt. For example, a patient who grew up with a depressed mother may believe that if she is successful and contented in life, she may make her mother feel bad simply by comparison. She may have a pervasive underlying feeling of survivor guilt towards her mother, and may weaken or inhibit herself by perfectionism or obsessive thinking. By weakening herself she avoids feeling guilty for being better off than her mother (O'Connor, in press).

Other researchers provide more clinical examples of the connection between inflated responsibility, guilt, and obsessive-compulsive symptoms. For example, Tallis (1994) offers two case summaries of patients with OCD where a specific learning experience gave rise to an inflated sense of responsibility, guilt, and the psychological fusion of thought and action. Tallis posits that childhood experiences may contribute to the development of certain features associated with OCD. In another study, Savoie (1996) interviewed nine patients with OCD to gain a better understanding of the role of guilt in O-C symptoms. From the interviews, Savoie derived fifteen guilt/OCD themes. Theme two he labels "hyper-responsibility/omnipotence" guilt. Patients report feeling responsible for the welfare of others and guilt if they ignore this responsibility. Sufferers believe they have omnipotent power in their ability to impact the fates of others. For example, a person

believes that thinking about a catastrophic event may cause it to happen (thought-action fusion), and performing rituals will prevent the event from happening. Theme fourteen is similar in that sufferers worry about getting better because they fear it makes them less careful and concerned people. They worry they are not acting responsibly enough (by ritualizing to prevent harm) and may therefore be the cause of another person's misfortune. Savoie concludes "that the role of guilt in OCD is highly interpersonal in nature" (p. 193).

While there is much evidence that points to the importance of interpersonal guilt in OCD, research on the topic is limited by the lack of an adequate instrument for measuring this type of guilt. Previous studies have used the Perceived Guilt Index or the Guilt Inventory to evaluate guilt's role in OCD (Niler and Beck, 1989; Rachman et al., 1995; Reynolds and Salkovskis, 1991). The PGI (Otterbacher & Munz, 1973) is a self-report measure of experiential guilt. The index has two subscales which assess guilt as an affective state of the person at the moment of rating (State Guilt), and as a generalized self concept (Trait Guilt). The GI (Kugler & Jones, 1992) is another self-report questionnaire that includes the subscales Trait Guilt, State Guilt, and Moral Standards. Neither the PGI nor the GI focus specifically on interpersonal guilt or concerns about harming others.

O'Connor, Berry, Weiss, Bush, and Sampson (1997) developed a new measure to assess guilt related to concern about harming others. The 67-item "Interpersonal Guilt Questionnaire" (IGQ-67) measures four types of interpersonal guilt: survivor guilt, separation guilt, omnipotent responsibility guilt, and self-hate guilt. In brief, survivor guilt is derived from the belief that one is harming others by surpassing them, or being better off, for example by being more successful or happier. Separation guilt is derived from the belief that one is disloyal and harming loved ones by leaving or by being different. Omnipotent responsibility guilt is derived from the belief that one is responsible for the well being of others, and that one has the power to make others successful or happy. Self-hate guilt is a severe negative evaluation of the self. Prior research using the IGQ-67 demonstrated that guilt was significantly correlated with the OCD subscale of the Brief Symptom Inventory (BSI: Derogatis, 1993; O'Connor, Berry, & Weiss, 1999). However, there have been

no studies focused exclusively on obsessive-compulsive symptoms using subscales of interpersonal guilt.

The present study further investigates the relationship between interpersonal guilt and obsessive-compulsive symptoms in a non-clinical sample of college students, using the IGQ-67, the Padua Inventory (PI: Sanavio, 1988), a 60-item self report measure of the most common obsessions and compulsions, and the Beck Depression Inventory (BDI-II: Beck, Steer & Brown, 1996). It is hypothesized, based on prior research, that omnipotent-responsibility guilt will be highly correlated with obsessive-compulsive symptoms, and in particular with checking compulsions and obsessional thinking. In addition, following the emphasis on the effects of childhood in the development of OCD suggested by Salkovskis (1998), Tallis (1994), and Weiss (1993), this study also investigates the relationship between OCD and childhood experiences, using a measure developed by Gilbert (1997).

Method

Participants

Participants were 116 college students from a large western state university who participated for credit in a psychology course. The sample included 41 men (35.3%) and 75 women (64.7%). The mean age of subjects was 20.5 with a standard deviation of 3.26. The ethnic identifications of subjects included 36 European Americans (31%), 1 African American (1%), 48 Asian Americans (41.4%), 16 Hispanic Americans (13.8%), 13 Mixed or Other (11.2%), and 2 unidentified (1.7%).

Instruments

The Interpersonal Guilt Questionnaire-67 (IGQ-67: O'Connor et al., 1997). The IGQ-67 is a 67-item, self-report questionnaire designed to assess four types of guilt related to a fear of harming others; the four subscales of the IGQ-67 are Survivor/Outdoing Guilt (22 items), Separation Guilt (16 items), Omnipotent Responsibility Guilt (14 items), and Self-hate (15 items). Responses to items are given on a 5-point Likert-type scale, and subscale scores are the sum of

item responses for that subscale (some items are reversed scored). Internal consistencies (Cronbach's alpha coefficients) for the subscales have ranged from .76 to .85 for Survivor/Outdoing Guilt, from .73 to .83 for Separation Guilt, from .71 to .83 for Omnipotent Responsibility Guilt, and from .84 to .89 for Self-hate (O'Connor & Berry, 1999; O'Connor et al., 1997; Menaker, 1995). The construct validity of the IGQ-67 has been established through correlations with other measures of guilt and with a variety of measures of psychopathology (O'Connor, Berry, Weiss, Herbold, Meehan & Webster, 1996; O'Connor et. al, 1997; O'Connor et al, 1999).

The Padua Inventory (PI; Sanavio, 1988). The PI is a 60-item, self-administered test that measures the most common obsessions and compulsions. Subjects are asked to reply to each statement on a zero to four scale. Zero indicates that the item is not at all disturbing, while four indicates that the item is very disturbing. Items factor into four categories: impaired control over mental activities, becoming contaminated, checking behaviors, and urges and worries of losing control over motor behaviors. The test shows high internal consistency and stability over time. Convergent and discriminant validity is satisfactory, and the PI shows good agreement with other self-report measures of OCD. Burns, Keortge, Fornea, and Sternberger (1996) revised the Padua Inventory but the convergent validity of the revised measure has yet to be established (Taylor, 1998), thus we chose to use the original PI in this study.

The Beck Depression Inventory (BDI-II: Beck, Steer, & Brown, 1996). The BDI is a frequently used, reliable, and well-validated measure of depression. The BDI is a 21-item self-report inventory representing cognitive, affective, and vegetative symptoms of depression.

Early Life Experiences Scale (ELES: Gilbert, 1997). This self-administered test is designed to explore how early childhood experiences relate to later psychological difficulties. The instrument consists of 51 questions that make up seven subscales: Guilt (8 items), Personal Shame (8 items), Family Shame (6 items), Humiliation (8 items), Emotional Neglect (8 items), Subordination (7 items), and Expectations (6 items). Responses to items are registered on a five point Likert scale. Subscale scores are the sum of the item responses for that subscale (some items are reverse

scored). Cronbach's alphas based on a previous study are .68 for Guilt, .88 for Personal Shame, .66 for Family Shame, .87 for Emotional Neglect, .75 for Subordination, and .82 for Expectations (Middaugh, O'Connor, Berry, Gilbert, & Mulherin, 1998).

Items from the Guilt subscale explore memories of feeling guilty for hurting others or for being selfish. Examples include "I often worried about hurting the feelings of others in my family," and "I often felt selfish if I did what I wanted to do." Items from the Personal Shame subscale explore memories of feeling ashamed of oneself and inadequate. An example of an item from this subscale is "My parents often made me feel inadequate and inferior." Family Shame is related to memories about shaming others. Examples include "My parents made it clear that I should not do anything that would show them up," and "I often worried about bringing disgrace to my family." The Humiliation subscale explores memories about being treated unfairly by family members, e.g., "I often did not deserve the punishment I was given." Items pertaining to Emotional Neglect include "My parents did not show interest in me," and "My parents often rejected my requests for help or affection." The Subordination subscale includes statements like "I often had to give-in to others at home," and "I rarely felt my opinions mattered much." The last subscale, Expectations, explores memories pertaining to having to meet the expectations of others. An example is "I often felt a disappointment to my family."

Procedure

Students in a large undergraduate psychology course were asked to participate in a research study for class credit. Those students who volunteered to participate were given a packet of the instruments described above, in addition to a demographic data questionnaire and a letter of introduction. It was emphasized that participation was voluntary and anonymous. Completion of the packets took approximately thirty to forty-five minutes. Subjects were asked to fill out the questionnaires and return them in packets to the researchers.

Results

Means and standard deviations for the depression, guilt, obsessive-compulsive symptoms, and early childhood experiences variables are summarized in Table 1. Table 2 shows the intercorrelations between these variables. The number of participants used in each computation ranged from 107 to 116.

Consistent with previous research, the subscales of the IGQ-67 are strongly correlated with each other. The subscales of the Padua Inventory are also highly correlated with each other -- again consistent with previous research .

The main hypotheses of the study were largely confirmed. As expected, depression was correlated significantly with all subscales of the IGQ-67, all subscales of the PI, and all subscales of the ELES. In addition, the subscales of the IGQ-67 were significantly correlated with the PI Total and all subscales of the PI, with the exception of the subscale measuring urges and worry about losing control over motor behavior. Contrary to our expectations, interpersonal guilt was not significantly correlated with humiliation and emotional neglect in childhood.

To determine whether interpersonal guilt was correlated with obsessive- compulsive symptoms independent of depression, we used a multiple regression predicting the PI scale scores from the BDI and the subscales of the IGQ-67. In Table 3 we present the partial correlations between the PI scales and the IGQ-67 subscales, controlling for BDI scores. While controlling for depression, guilt remained correlated with most of the PI scales. However, as with the zero-order correlations, guilt did not substantially predict PI scores for worry about loss of impulse control over motor behavior. Also, Survivor Guilt appears to account only for the Mental Control subscale of the PI.

In Table 4 we present partial correlations between the PI scales and the BDI, controlling for the subscales of the IGQ-67. BDI scores, even when controlling for guilt, remained significantly correlated with all PI scale scores. Thus, both depression and interpersonal guilt provided independent contributions to predicting many obsessive-compulsive symptoms, with depression related more strongly and with a wider variety of symptoms.

Discussion

The results of this study are consistent with clinical data and recent theorizing about the role of guilt in OCD. Previous empirical research, however, has been somewhat inconsistent in demonstrating the significance of guilt in obsessive thinking and compulsive behavior. In this study we used the IGQ-67, which directly measures the kind of guilt described in the clinical literature, that is, guilt related to a sense of omnipotent responsibility for others. In addition to lending empirical evidence to the contribution of omnipotent responsibility guilt in OCD, this study also found that both separation and survivor (outperformance) guilt were significantly related to obsessive-compulsive symptoms. Such results are predicted by Weiss's theory of psychopathology (Weiss, 1986; 1993), and demonstrated in one prior empirical study (O'Connor et al., 1999).

In this study we found that both guilt and depression independently predicted obsessive-compulsive symptoms. Depression accounted for more of the variance than did guilt, and was significantly predictive of each subscale of the PI. Interpersonal guilt was independently correlated with all but the fourth subscale of the PI, that is the measure of urges and worry about losing control over motor behaviors. We suggest that because this subscale refers to urges of a violent or antisocial nature (Sanavio, 1988), it follows that it is less likely to correlate with interpersonal guilt.

With few exceptions, OCD symptoms were highly correlated with a negative family environment, as measured by the ELES. Such results support the theoretical assertion that childhood experiences may contribute to the development of OCD (Salkovskis, 1998; Tallis, 1994; and Weiss, 1993). However, it is also possible that depressed, ruminating adults who are highly prone to obsessive thinking are more likely to describe their childhood experiences as negative, whether or not these same experiences might be so described by less depressed or obsessive individuals. Independent of childhood experiences and environmental influences, there is also much evidence linking OCD to a biological abnormality involving the serotonin neurotransmitter system (Gross, Sasson, Chopra, & Zohar, 1998).

Overall, the results of this study are consistent with current cognitive theories of OCD which emphasize the role of guilt and an exaggerated sense of personal responsibility in explaining obsessive-compulsive symptoms. The clinical implications of our results suggest the importance of helping patients overcome guilt feelings and irrational and inhibiting beliefs about their ability to cause harm to others.

A limitation of this study is that subjects were a young non-clinical sample at a large urban university. It is possible that these results may not generalize to a broader population, or to a clinical population. More research looking at the relationship between obsessive-compulsive symptoms and interpersonal guilt, including Survivor Guilt, Omnipotent Responsibility Guilt, and Separation Guilt, should be conducted using clinical samples.

References

Antony, M., Downie, F., & Swinson, R. (1998). Diagnostic issues and epidemiology in obsessive-compulsive disorder. In R. Swinson, M. Antony, S. Rachman, & M. Richter (Eds.), Obsessive-compulsive disorders: theory, research and treatment. (pp. 3-32). New York: Guilford Press

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). Beck Depression Inventory manual (2nd ed.). San Antonio, TX: Psychological Corporation.

Burns, G. L., Keortge, S. G., Fornea, G. M., & Sternberger, L. G. (1996). Revision of the Padua Inventory of obsessive-compulsive disorder symptoms: Distinctions between worry, obsessions and compulsions. Behaviour Research and Therapy, 34, 163-173.

Bush, M. (1989). The role of unconscious guilt in psychopathology and psychotherapy. Bulletin of the Menninger Clinic, 53(2), 97-107.

Derogatis, L. R. (1993). Brief Symptom Inventory (BSI). Administration, scoring and procedures manual. Minneapolis National Computer Systems.

Freeston, M., Ladouceur, R., Thibodeau, N., & Gagnon, F. (1992). Cognitive intrusions in a non-clinical population. Behaviour Research and Therapy, 30, 273-281.

Gilbert, P. (1997). Early Life Experiences Scale: Development of a new measure. Unpublished manuscript.

Gross, R., Sasson, Y., Chopra, M., & Zohar, J. (1998). Biological models of obsessive-compulsive disorder: The serotonin hypothesis. In R. Swinson, M. Antony, S. Rachman, & M. Richter (Eds.), Obsessive-compulsive disorder: Theory, research, and treatment, (pp. 141-153). New York: Guilford.

Hollander E., & Wong C. (1995, June). A pharmacoeconomic and quality of life study of OCD - what patients say. Presented at 1st International Congress on Education and Progress in OCD, Barcelona, Spain.

Hollander, E., & Benzaquen, S. (1997). The obsessive-compulsive spectrum disorders. International Review of Psychiatry, 9, 99-110.

Kugler, K. E., & Jones, W. H. (1992). On conceptualizing and assessing guilt. Journal of Personality and Social Psychology, 62, 318-327.

Lopatka, C., & Rachman, S. (1995). Perceived responsibility and compulsive checking: an experimental analysis. Behaviour Research and Therapy, 33, 673-684.

Menaker, A. (1995). The relationship between attributional style and interpersonal guilt. Unpublished doctoral dissertation, California School of Professional Psychology, Alameda, CA.

Middaugh, E., O'Connor, L., Berry, J., Gilbert, P., & Mulherin, K. (1998, April). The relationship between childhood experiences and interpersonal guilt and shame. Poster session presented at the annual meeting of the Western Psychological Association, Albuquerque, NM.

National Institute of Mental Health. (1996). Obsessive-compulsive disorder. [Brochure]. Washington, DC: U. S. Government Printing Office.

Niler, E. R., & Beck, S. J. (1989). The relationship among guilt, dysphoria, anxiety, and obsessions in a normal population. Behaviour Research and Therapy, 3, 213-220.

O'Connor, L. E. (in press). Pathogenic beliefs and guilt in human evolution: Implications for psychotherapy. In P. Gilbert & K. Bailey (Eds.), Genes on the Couch: Explorations in Evolutionary Psychotherapy. Guilford: New York.

O'Connor, L. E., Berry, J. W., & Weiss, J. (1999). Interpersonal guilt, shame, and psychological problems. Journal of Social and Clinical Psychology, 18 (2), 181-203.

O'Connor, L. E., Berry, J. W., Weiss, J., Bush, M., & Sampson, H. (1997). Interpersonal guilt: the development of a new measure. Journal of Clinical Psychology, 53, 73-89.

O'Connor, L. E., Berry, J. W., Weiss, J., Herbold, J., Meehan, W., & Webster, R. (1996). Interpersonal guilt and psychopathology: Development of a new measure. Poster presented at the meetings of the California Psychological Association, San Diego, California.

Otterbacher, J., & Munz, D. (1973). State-trait measure of experiential guilt. Journal of Consulting and Clinical Psychology, 40, 115-121.

Rachman, S. (1993). Obsessions, responsibility and guilt. Behaviour Research and Therapy, 2, 149-154.

Rachman, S., & Hodgson, R. (1980). Obsessions and compulsions. New York: Prentice Hall.

Rachman, S., & de Silva, P. (1978). Abnormal and normal obsessions. Behaviour Research and Therapy, 16, 233-248.

Rachman, S., Thordarson, D., Shafran, R, & Woody, S. (1995). Perceived responsibility: Structure and significance. Behaviour Research and Therapy, 33, 779-784.

Ratey, J. J. & Johnson, C. (1997). Shadow syndromes: The mild forms of major mental disorders that sabotage us. New York: Bantam Books.

Reynolds, M., & Salkovskis, P. (1991) The relationship among guilt, dysphoria, anxiety and obsessions in a normal population—an attempted replication. Behaviour Research and Therapy, 29, 259-265.

Salkovskis, P. (1985). Obsessional-compulsive problems: a cognitive-behavioral analysis. Behaviour Research and Therapy, 23, 571-583.

Salkovskis, P. (1989). Cognitive-behavioural factors and the persistence of intrusive thoughts in obsessional problems. Behaviour Research and Therapy, 27, 677-682.

Salkovskis, P. (1998). Psychological approaches to the understanding of obsessional problems. In R. Swinson, M. Antony, S. Rachman, & M. Richter (Eds.), Obsessive-compulsive disorder: Theory, research, and treatment, (pp. 33-50). New York: Guilford.

Salkovskis, P., & Harrison, J. (1984). Abnormal and normal obsessions—a replication. Behaviour Research and Therapy, 22, 549-552.

Sanavio, E. (1998). Obsessions and compulsions: the Padua Inventory. Behaviour Research and Therapy, 26, 169-177.

Savoie, D. (1996). A phenomenological investigation of the role of guilt in obsessive-compulsive disorder. Journal of Phenomenological Psychology, 27, 193-218.

Shafran, R., Watkins, E., & Charman, T. (1996). Guilt in obsessive-compulsive disorder. Journal of Anxiety Disorders, 10, 509-516.

Steketee, G., Quay, S. & White, K. (1991). Religion and guilt in OCD patients. Journal of Anxiety Disorders, 5, 359-367.

Sternberger, L. G., & Burns, G. L. (1990). Obsessions and compulsions: Psychometric properties of the Padua Inventory with an American college population. Behaviour Research and Therapy, 28, 341-345.

Tallis, F. (1994). Obsessions, responsibility, and guilt: two case reports suggesting a common and specific aetiology. Behaviour Research and Therapy, 32, 143-145.

Taylor, S. (1998). Assessment of obsessive-compulsive disorder. In R. Swinson, M. Antony, S. Rachman, & M. Richter (Eds.), Obessessive-compulsive disorders: theory, research and treatment. (pp. 229-257). New York: Guilford Press

Weiss, J. (1983). Notes on unconscious guilt, pathogenic beliefs, and the treatment process. Bulletin #6. The San Francisco Psychotherapy Research Group, Department of Psychiatry, Mount Zion Hospital and Medical Center.

Weiss, J. (1986). Unconscious Pathogenic Beliefs. In J. Weiss & H. Sampson (Eds.), The psychoanalytic process: Theory, clinical observation and empirical research (pp. 68-83). New York: Guilford.

Weiss, J. (1993). How Psychotherapy Works. New York: Guilford.

Weiss, J., Sampson, H., & The Mount Zion Psychotherapy Research Group (1986). The psychoanalytic process: Theory, clinical observation and empirical research. New York: Guilford.

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Table 1

Descriptive Statistics For Depression, Guilt, Early Life Experiences, And Obsessive-Compulsive Variables

Variable	N	M	SD
BDI	116	13.5	10.8
IGQ-67			
Interpersonal Guilt	115	150.5	21.2
Survivor Guilt	116	63.2	9.9
Separation Guilt	115	41.4	7.9
Omnipotent Responsibility	116	45.9	7.6
Self-hate	116	34.8	10.0
ELES			
Guilt	111	21.5	5.7
Personal Shame	109	17.4	7.0
Family Shame	111	14.9	6.1
Humiliation	111	19.1	7.7
Emotional Neglect	112	17.3	7.9
Subordination	110	17.6	5.3
Expectations	111	14.9	4.9
PI			
Mental control	112	13.7	10.0
Contamination	113	7.3	6.7
Checking	114	6.2	4.6
Impulses	115	2.8	3.1
PI Total	108	39.4	29.5

BDI = Beck Depression Inventory; IGQ = Interpersonal Guilt Questionnaire; PI = Padua Inventory; ELES = Early Life Experiences Scale

Table 2

Correlation Matrix For Depression, Guilt, Early Life Experiences, And Obsessive-Compulsive Variables

		IGQ-67					PI				ELES					
	BDI	IntTot	Surv	Sep	Omni	SHate	MCtl	Cont	Check	Imp	Guilt	PersSh	FamSh	Humil	EmNeg	Sub
IGQ-67																
IntTot	.44***	—														
Surv	.39***	.87***	—													
Sep	.34***	.82***	.54***	—												
Omni	.34***	.85***	.60***	.60***	—											
SHate	.61***	.61***	.52***	.55***	.47***	—										
PI																
MCtl	.57***	.57***	.49***	.47***	.49***	.62***	—									
Cont	.41***	.39***	.24**	.39***	.38***	.46***	.72***	—								
Check	.47***	.44***	.32***	.42***	.39***	.40***	.68***	.64***	—							
Imp	.49***	.20*	.17	.22*	.11	.45***	.61***	.56***	.45***	—						
ELES																
Guilt	.51***	.57***	.49***	.38***	.52***	.62***	.45***	.30**	.31**	.39***	—					
PersSh	.56***	.40***	.41***	.20*	.33**	.59***	.49***	.32**	.40***	.46***	.76***	—				
FamSh	.33***	.27**	.23*	.28**	.17	.44***	.29**	.19	.31**	.35***	.53***	.60***	—			
Humil	.39***	.15	.17	.01	.16	.42***	.35***	.22*	.31**	.38***	.58***	.77***	.68***	—		
EmNeg	.32**	.12	.14	.02	.11	.30**	.27**	.14	.19*	.24*	.45***	.64***	.21*	.54***	—	
Sub	.59***	.36***	.33***	.19	.33***	.48***	.53***	.40***	.49***	.53***	.63***	.78***	.49***	.68***	.66***	—
Exp	.50***	.34***	.30**	.24**	.28**	.48***	.49***	.38***	.36***	.45***	.63***	.81***	.55***	.60***	.51***	.66***

* $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$

Table 3

Partial Correlations Predicting Obsessive-Compulsive Symptoms From Guilt, Controlling For Depression

Predictor: Controlling for:	Survivor BDI	Separation BDI	Omnipotence BDI	Self-hate BDI	Interpersonal BDI
PI Scales					
Mental control	.35***	.28**	.39***	.41***	.43***
Contamination	.10	.25**	.28**	.29**	.25**
Checking	.17	.24*	.28**	.16	.29**
Impulses	-.03	.02	-.06	.22*	-.02
PI Total	.21*	.30**	.32**	.37***	.35***

* $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$

Table 4

Partial Correlations Predicting Obsessive-Compulsive Symptoms From Depression, Controlling For Guilt

Predictor: Controlling for:	BDI Survivor	BDI Separation	BDI Omnipotence	BDI Self-hate	BDI Interpersonal
PI Scales					
Mental control	.47***	.50***	.49***	.31**	.43***
Contamination	.36***	.33***	.33***	.19*	.30**
Checking	.40***	.40***	.40***	.32**	.35***
Impulses	.47***	.46***	.48***	.31**	.46***
PI Total	.52***	.53***	.53***	.36***	.48***

* $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$