

# Guilt, Shame, Empathy, Self-Esteem, and Traumas: New Data for the Validation of the Interpersonal Guilt Rating Scale–15 Self-Report (IGRS-15s)

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*Abstract:* The aim of this paper is to present further data for the validation of the Interpersonal Guilt Rating Scale-15 self-report (IGRS-15s; Gazzillo et al., 2018). We recruited a sample of 448 subjects, to whom we administered the IGRS-15s together with other empirically validated measures for the assessment of social desirability, shame, self-esteem, empathy, mental health and therapeutic alliance. In line with our hypotheses, the previously established three-factor structure of the IGRS-15s (Survivor guilt, Omnipotence guilt, and Self-hate) was confirmed. Moreover, the internal consistency and test-retest reliability of IGRS-15s were adequate to good. All the IGRS-15s factors were negatively correlated with self-esteem and mental health and positively correlated with shame; Survivor guilt and Omnipotence guilt were positively correlated with empathy; Survivor guilt and Self-hate negatively affected therapeutic alliance; and different traumas had different, theoretically predictable, impacts on the different kinds of guilt. Overall, these data support the reliability and validity of the IGRS-15s.

*Keywords:* CMT, IGRS-15s, interpersonal guilt, shame, traumas

Recent developments in biology and moral and evolutionary psychology (Engelmann & Tomasello, 2018; Haidt, 2012; Sober & Wilson, 1998; Tomasello, 2016; D. S. Wilson, 2015; E. O. Wilson, 2012) consider guilt to be one of the results of the evolution of the human species as a eusocial species and functional to group survival. In line with this, the integrated,

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Psychodynamic Psychiatry, 48(1), 79–100, 2020

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cognitive-dynamic relational Control-Mastery Theory (CMT; Gazzillo, 2016; Silberschatz, 2005; Weiss, 1993; Weiss, Sampson, & The Mount Zion Psychotherapy Research Group, 1986) argues that guilt has an interpersonal origin and an adaptive function. Moral emotion par excellence, guilt is based on children's need to preserve their attachment relationship with caregivers and siblings, and to feel that people around them love and are happy with them (Bush, 2005; O'Connor, 2000).

In their efforts to adapt to reality, children develop a set of implicit and explicit schemas and beliefs about themselves, other people, and the world (Weiss, 1997). These beliefs drive children in their adaptation, indicating to them how to behave in a given environment; what to expect from others; which motivations, feelings, attitudes, and behaviors can or should be felt and/or manifested; and which feelings are to be avoided or inhibited. These beliefs are shaped by direct and indirect communications from caregivers and their examples, and represent reality for the child or person (Sampson, 1992). However, they are also shaped by the children's cognitive and emotional immaturity, in particular by their egocentricity and tendency to feel excessively responsible for things that happen, and their lack of experience. What caregivers say, do, and think is for the children both reality and a moral imperative that must be respected in order to be able to adapt to their environment.

Some of a person's beliefs may be considered pathogenic (Weiss et al., 1986) when they associate the achievement of pleasurable and healthy goals to a situation of internal (e.g., fear, guilt, shame, etc.) or external (e.g., punishment, suffering of other people, loss of loved ones, etc.) danger. Pathogenic beliefs derive from traumas and adverse childhood experiences, and may be thought of as attempts to understand what the person did to cause these traumas and how s/he can prevent them in the future.

We know that guilt is connected to motivational systems of fear, attachment, and care (Gazzillo et al., 2018), derives from the ability to empathically feel other people's suffering combined with a feeling of responsibility for that distress (Hoffman, 2000), and motivates attempts to repair (Tangney & Dearing, 2002). However, guilt may become pathogenic when shaped or strengthened by pathogenic beliefs. In some circumstances, in fact, pro-social behaviors resulting from excessive empathic concern for others may lead to self-sabotaging behaviors and psychological problems (Berghold & Lock, 2002; Blair, 2005; Bruno, Lutwak, & Agin, 2009; Decety & Moriguchi, 2007; Giammarco & Vernon, 2015; Locke, Shilkret, Everett, & Petry, 2013, 2015; Meehan, O'Connor, Berry, & Weiss, 1996; O'Connor, Berry, & Weiss, 1999; O'Connor, Berry, Lewis, Mulherin, & Crisostomo, 2007; O'Connor, Berry, Weiss, & Gilbert, 2002; Zahn-Waxler & Schoen, 2016; Zahn-Waxler & Van Hulle, 2011).

In line with the hypotheses of some American psychoanalysts (Asch, 1976; Loewald, 1979; Modell, 1965, 1971; Niederland, 1981), CMT (Gazzillo et al., 2019) identifies five types of interpersonal guilt.

1. *Survivor guilt*, based on the pathogenic belief that having more success, satisfaction, good fortune, or other positive qualities than important others may hurt them.
2. *Separation/disloyalty guilt*, based on the pathogenic belief that separating physically or psychologically from loved ones can cause them harm.
3. *Omnipotent responsibility guilt*, based on the pathogenic belief that one must, and has the power to, make loved ones happy, so that putting the satisfaction of own needs to the fore means being selfish and hurting them.
4. *Burdening guilt*, which derives from the pathogenic belief that one's emotions and needs are a burden to loved ones, and that one's own problems and fragility cannot be expressed because this would hurt them.
5. *Self-hate*, which is based on the pathogenic beliefs of being bad, rotten, inadequate, and worthless. Unlike the other kinds of guilt, this is a self-accusation about what one is, rather than what one has done or might potentially do; its interpersonal origin derives from the fact that in the presence of neglectful or abusive parents, it is safer for a child to think that he or she deserves the mistreatment s/he suffers rather than feeling dependent on parents who are actually bad (Fairbairn, 1943).

The first empirical tool for assessing guilt from a CMT perspective was the Interpersonal Guilt Questionnaire-67 (IGQ-67; O'Connor, Berry, Weiss, Bush, & Sampson, 1997). It assesses Survivor guilt (22 items), Separation guilt (15 items), Omnipotent guilt (14 items), and Self-hate (16 items). The categorization of the items into the four subscales was based on a top-down, theoretically driven procedure and was not confirmed by factor analysis, which actually yielded a two-factor solution: Self-hate and Composite guilt (survivor, separation, and omnipotent responsibility guilt).

In the last few years, however, our research group has developed and validated a clinician report for assessing Survivor guilt, Separation/disloyalty guilt, Omnipotent responsibility guilt, and Self-hate—the Interpersonal Guilt Rating Scale-15 (IGRS-15; Gazzillo et al., 2017). The IGRS-15's empirically derived four-factor solution is in line with the theoretical differentiation of the four kinds of guilt that the tool is intended to assess, and the first results on its test-retest reliability and convergent and dis-

criminant validity are encouraging. Moreover, thanks to its brevity the IGRS-15 can easily be used for both clinical and research purposes.

We subsequently developed and validated a self-report version of this tool, the Interpersonal Guilt Rating Scale–15 self-report (IGRS-15s; Gazzillo et al., 2018), whose factor analysis suggested a three-factor solution: Survivor guilt (5 items), Omnipotence guilt (7 items), assessing both separation disloyalty and omnipotent responsibility guilt, and Self-hate (3 items). The concordant and discriminant validity of the IGRS-15s, assessed using the IGQ-67 as one of the criterion measures, was good. Moreover, in order to test the construct validity of the IGRS-15s, we calculated the correlation between our IGRS-15s factors and the primary affective systems assessed by the Affective Neuroscience Personality Scale (Davis, Panksepp, & Normansell, 2003). As theoretically predicted, the data showed that Survivor guilt and Omnipotence guilt were both connected to the affective systems of Fear, Attachment, and Care, while Self-hate was correlated with Sadness/ Attachment and Fear. In other words, Survivor guilt and Omnipotence guilt assess to what degree a person is afraid (fear) of losing or having lost a loved one or her/his love (sadness/ attachment) or of having hurt her/him (care); and Self-hate expresses the feeling of being afraid of not being loveable because of how one thinks and feels one is. Moreover, Self-hate was also associated with Anger and, inversely, with Seeking and Play affective systems. This would appear to suggest that feeling inadequate and worthless tends to inhibit feelings of looking eagerly for something better (Seeking) and the pleasant excitation involved in Play, and tends instead to be connected to feelings of Rage. Finally, again as expected, correlations between the IGRS-15s factors and well-being as assessed by the Psychological General Well-Being Index (PGWBI; Dupuy, 1984) were negative and significant for all the IGRS-15s factors and particularly for Self-hate.

The aim of this article is to present further results on the validation of the IGRS-15s, and to empirically investigate the relationship between interpersonal guilt assessed using the IGRS-15s and social desirability, empathy, shame, self-esteem, mental health, therapeutic alliance, and childhood traumatic experiences.

## METHOD

### Sample

In order to be included in this study, participants had to be 18 years old or older and have no diagnosis of addiction, psychosis, or damage to the central nervous system.

The sample was recruited from college students in the Faculty of Medicine and Psychology at the “Sapienza” University of Rome, along with their friends and relatives, and patients of the clinicians in the Control-Mastery Theory Italian Group (CMT-IG), between October 2018 and January 2019. Participation was anonymous and voluntary, and no fee was given. Data were collected in the areas of Rome, Turin, Aosta, Palermo, Milan, and Salerno. In order to reduce order effects, the various questionnaires in paper-and-pencil format were administered to participants in random order.

Our sample was composed of 448 subjects. The average age was 28.79 years ( $SD = 11.17$ ; ranging from 18 to 77 years); 272 were female (60.7%) and 176 were male (39.3%). The distribution of educational levels in our sample was as follows: one person (0.2%) had completed only first-grade; 21 (4.7%) had completed middle school; 231 (51.9%) had completed high school; 146 (32.8%) had completed college; 46 (10.3%) had received post-graduate education; and for three subjects, data were missing.

The sample’s socioeconomic status was as follows: 58 (13%) were poor; 360 (80.7%) were working to middle class; and 28 (6.3%) were upper class. Here too, data for three subjects were missing.

A total of 163 subjects (36.4%) were in psychotherapy, while 285 (63.6%) were not.

## Measures

The Interpersonal Guilt Rating Scale–15 Self-Report (IGRS-15s; Gazzillo et al., 2018). The IGRS-15s is a 15-item, self-report rating scale assessing interpersonal guilt as conceived according to CMT. A previous factor analysis conducted on another Italian sample pointed to a three-factor solution differentiating Survivor guilt, Omnipotence guilt (comprising both Omnipotent responsibility guilt and Separation/Disloyalty guilt), and Self-hate. Each item is assessed on a 5-point rating scale, ranging from 1 (not representative at all) to 5 (completely representative). The concurrent and discriminant validity of the IGRS-15s were determined using as criterion measures the Interpersonal Guilt Questionnaire–67 (IGQ-67; O’Connor et al., 1997) and the Fear of Punishment/Need for Reparation Scales (FPNRS; Caprara, Perugini, Pastorelli, & Barbaranelli, 1990). Its construct validity was assessed using the Affective Neuroscience Personality Scale (ANPS; Davis et al., 2003) and the Psychological General Well-Being Index (PGWBI; Dupuy, 1984).

*The Socio-Demographic Schedule* (Gazzillo & Faccini, 2019). This is a brief, ad hoc self-report tool composed of 11 forced-choice questions designed to collect data on age, gender, education, socioeconomic status, and the presence of trauma in early childhood.

*The Marlowe Crowne Social Desirability Scale* (MCSDS; Crowne & Marlowe, 1960), administered in the 9-item Italian version (SDS; Manganelli Rattazzi, Canova, & Marcorin, 2000). Here, items are rated on a 7-point Likert scale, ranging from 1 (absolutely false) to 7 (absolutely true). A total score is derived by summing the scores for all the items, with higher scores indicating higher levels of social desirability. Internal consistency was acceptable (Cronbach's  $\alpha = .70$ ). Some example of the items of this scale are: "I am always kind, to unpleasant people too"; "When I make a mistake, I am always willing to admit it"; "I have never intentionally said anything that could hurt someone's feelings."

*The Other As Shamer Scale* (OAS; Goss et al., 1994) in its version validated in Italy (Balsamo et al., 2015). The scale includes 18 items, selected from the 25-items of the Internalized Shame Scale (ISS; Cook, 1993), and is aimed at measuring global judgments about how the self is evaluated by others. Respondents are asked to rate the frequency with which they make certain evaluations on a five-point Likert-type scale, ranging from 0 (never) to 4 (almost always). Total scores, calculated by summing together all the item scores, range from 0 to 72, with higher scores indicating greater external shame. Cronbach's  $\alpha$  for this scale is .92 (Goss et al., 1994). The OAS factor structure is made up of three main factors, which accounted for 60.4% of the total variance: Inferiority, which is composed of seven items, relates to being seen as inferior; Emptiness, which consists of four items, relates to being seen as empty; and Mistake, which consists of six items, relates to how others are seen as being alert to the mistakes one makes (Goss et al., 1994). Items include the following: "I feel other people see me as not good enough"; "Other people always remember my mistakes"; "Other people think I have lost control over my body and feelings."

*The Rosenberg Self-Esteem Scale* (SES; Rosenberg, 1965) in its Italian version (Prezza, Trombaccia, & Armento, 1997). This tool provides a measure of self-esteem and contains 10 items measured on a 4-point Likert scale, ranging from 1 (strongly disagree) to 4 (strongly agree). Total scores range from 11 to 40, where higher scores indicate higher levels of self-esteem. The Italian version of the SES has demonstrated good reliability (Cronbach's  $\alpha = .84$ ). Its validity was determined using the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988), the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), and the Life Satisfaction in the Elderly Scale (LSES; Salamon & Conte, 1984). Items include: "I feel that I have a number of good qualities"; "I feel I do not have much to be proud of."

*The Basic Empathy Scale* (BES; Jolliffe & Farrington, 2006) in its version validated in Italy (Albiero, Matricardi, Speltri, & Toso, 2009). The scale

comprises a total of 20 items and is composed of two subscales identifying two different components of empathic responsiveness: the Affective Empathy subscale (11 items,  $\alpha = .86$ ), measuring emotional congruence with others' emotions; and the Cognitive Empathy subscale (nine items,  $\alpha = .74$ ), measuring the ability to understand another person's emotions. A total score is calculated by merging the two subscales (20 items,  $\alpha = .87$ ). Each item asks participants to express their degree of agreement on a 5-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). The BES was adapted for the Italian population through a back-translation method to ensure the semantic equivalence of the Italian and English versions. It correlates with previously published measures of empathy (Empathic concern and Perspective-taking; Davis, 1983), and with Emotional empathy as assessed using the Balanced Emotional Empathy Scale (BEES; Mehrabian, 1996). Example of items are: "When someone is feeling 'down,' I can usually understand how they feel"; "I get caught up in other people's feelings easily."

*The Short Form-12 Health Survey* (SF12; Ware et al., 1996). This 12-item short form was developed from the original Short Form-36 Health Survey (Bullinger, 1995; Bullinger & Kirchberger, 1998; Ware, Snow, Kosinski, & Gandek, 1993). This internationally and widely used measure has proven to be a psychometrically robust and easy-to-use tool for outcome assessments of subjective health functioning across different countries and populations (Bullinger, 1996; Bullinger & Kirchberger, 1998; Gandek et al., 1998). It assesses the following aspects of subjective health: physical functioning, role limitations due to physical and emotional health problems, freedom from body pain, general health perception, vitality, social functioning, and mental health. From these eight dimensions, a physical (PCS) and a mental (MCS) summary health score can be calculated, using the scoring algorithm outlined in the manual (mean = 50;  $SD = 10$ ). The lower the resulting score, the lower the self-reported subjective health functioning. Items include: "In the last 4 weeks, have you had any of the following problems with your work or other regular daily activities, as a result of any emotional problems (such as feeling depressed or anxious)?"

*The Working Alliance Inventory-Short form* (WAI-S; Tracey & Kokotovic, 1989), directly derived from the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). The inventory consists of three subscales representing Bordin's (1979) multidimensional theoretical conceptualization of therapeutic alliance (Goals, Tasks, and Bonds). It has 12 items in all—four for each subscale—with each item rated on a 7-point Likert

scale, ranging from 1 (never) to 7 (always). Two of the items are inverted (items 4 and 10). The scale provides four different scores: three subscale scores and an aggregate overall score. Total scores range from 12 to 84, with higher scores reflecting a stronger working alliance. WAI-S scores in a pilot study on a Flemish sample proved to be reliable (alphas between .82 and .85; Stinckens, Ulburghs, & Claes, 2009). The following are example of items: “What I am doing in therapy gives me new ways of looking at my problem”; “We agree on what is important for me to work on”; “I believe the way we are working with my problem is correct.”

### Procedure

In order to check the factor structure of the tool obtained in a previous study, we performed a confirmatory factor analysis (CFA).

In order to assess the test-retest reliability of the IGRS-15s, we re-administered it to a random subsample of 47 subjects four weeks after the first administration. We then calculated Spearman correlations between the two assessments. We used Spearman correlations because the IGRS-15s data were not normally distributed.

To assess the relationship between the different empirically derived factors of the IGRS-15s, the OAS, the SDS, the SES, and the WAI-S, we used Spearman correlation coefficients.

To assess whether the different kinds of guilt assessed by the IGRS-15s were associated with different socio-demographic variables and the presence of trauma in childhood, we used, respectively, Spearman product-moment correlations and the Mann-Whitney U-test.

Confirmatory factor analysis was performed with the lavaan package in R (Rosseel, 2012), while all other data analyses were conducted in SPSS–Version 22.

### Hypotheses

Our hypotheses were that:

1. The three-factor structure of the IGRS-15s, which differentiates Survivor guilt, Omnipotence guilt, and Self-hate, would also be confirmed in this new sample.
2. The test-retest reliabilities of our IGRS-15s scales would be acceptable to good.
3. There would be no significant correlations between the IGRS-15s scales and socio-demographic variables, apart from a higher level of Survivor guilt and Omnipotence guilt in females as they tend to be more empathic than males; and that scores on all the IGRS-15s



subscales would be higher for people in treatment than for those not in treatment.

4. The IGRS-15s scales would not be correlated with the *SDS* (social desirability).
5. All the IGRS-15s scales would be positively and significantly correlated with the *OAS* (shame).
6. All the IGRS-15s scales would be negatively correlated with the *SES* (self-esteem).
7. Survivor guilt and Omnipotence guilt, but not Self-hate, would be positively and significantly correlated with Affective empathy and Total empathy; for, while Survivor guilt and Omnipotence derive from the emotional empathic perception of loved people suffering for having less than the subject or being in pain, Self-hate derives from the feeling of not deserving love, respect, care, and happiness, and so is not correlated with empathy.
8. The IGRS-15s scales would show a negative correlation with the Mental Health scale of the *SF12*.
9. Survivor guilt and Self-hate would show a negative correlation with therapeutic alliance as measured with the *WAI-S*. And finally,
10. In line with CMT hypotheses, Self-hate would be stronger in subjects who self-reported having been abused or neglected, and who felt they were a burden to their caregivers; Survivor guilt and Omnipotence guilt would be greater in people who perceived their parents to have more psychological and physical problems than they themselves did, who felt they had to take care of their parents, and who felt that their parents suffered because of their physical or psychological differentiation from them.

## RESULTS

A three-factor analysis solution model (Survivor guilt; Omnipotence guilt; Self-hate), based on previous research with this tool (IGRS-15s; Gazzillo et al., 2018), was proposed. Confirmatory factor analysis (CFA) and network analysis of 448 cases were conducted. All 15 items were submitted to the R (R Core Team, 2018) Structural Equation Model program, *lavaan* (Rosseel, 2012). As the IGRS items are ordered, categorical items, they were estimated using Diagonally Weighted Least Squares (DWLS; Muthén, 1993) fit criterion. The item wordings and loadings are displayed in Table 1. All items were statistically significantly correlated with their purported factors. The fit of the three-factor model was excellent (CFI = .98, TLI = .97, rmsea = .063,  $\chi^2 = 236$ ,  $df = 87$ ,  $rnr = .06$ ). Correlations among the factors are shown in Table 2 and indicated that

Table 1. Three-Factor Confirmatory Factor Analysis

Factor	Item	Item Wording	Loadings
Survivor	igrs7	The idea of being envied makes me acutely uncomfortable.	0.61
Survivor	igrs2	I feel uncomfortable feeling better off than other people.	0.83
Survivor	igrs4	I feel uncomfortable when I believe that I am better than others.	0.77
Survivor	igrs12	I conceal or minimize my successes out of concern for making less successful people feel bad.	0.76
Survivor	igrs15	I feel uncomfortable when I receive better treatment than others.	0.74
Omnipotence	igrs5	I feel selfish and insensitive if I am not the person who takes care of other people.	0.68
Omnipotence	igrs13	I would feel bad if I doubted about the values and beliefs of my family.	0.29
Omnipotence	igrs9	I feel overly responsible for other people's well-being.	0.77
Omnipotence	igrs3	I feel it is my responsibility to fix other people's problems.	0.75
Omnipotence	igrs8	I feel I should visit my parents as often as they wish.	0.45
Omnipotence	igrs14	I think I should not separate from loved ones because this would be hurtful, disloyal, or make them feel abandoned.	0.49
Omnipotence	igrs10	I tend to put aside my interests, needs, and passions to take care of other people.	0.55
Self-hate	igrs1	I believe that if other people really know me, they would want nothing to do with me.	0.8
Self-hate	igrs11	I do not deserve to be happy.	0.79
Self-hate	igrs6	I believe I have tricked other people into liking me.	0.85

All loadings were statistically significant at the .05 level or less.

the factors were mutually correlated. Therefore, the IGRS-15s items are shown to have a hierarchical structure in which three distinct factors can be seen to be nested in an overall general guilt factor.

A network analysis was performed with the JASP (JASP Team, 2018) implementation of the Epskamp, Borsboom, and Fried (2106) extended Bayesian (EBICglasso) model. Significant correlations between the items are represented by lines, with stronger correlations represented by darker lines. As can be seen from the graphical analysis, the items in each factor cluster together tightly, and item clusters are closely related (see Figure 1).

The *internal consistency* of the three guilt factors (Cronbach's alpha values) was acceptable to good: Survivor = .82; Omnipotence = .73; Self-hate = .78. The alpha level of the overall scale was good (alpha = .83).

The average score of these different kinds of guilt in our sample were: Survivor guilt, 2.28 ( $SD = .83$ ); Omnipotence guilt, 2.53 ( $SD = .65$ ); and Self-hate, 1.64 ( $SD = .77$ ).

Table 2. IGRS-15s Factors Intercorrelations

	1	2	3
Survivor	1		
Omnipotence	.49**	1	
Self-hate	.49**	.28**	1

\*\* $p < .01$

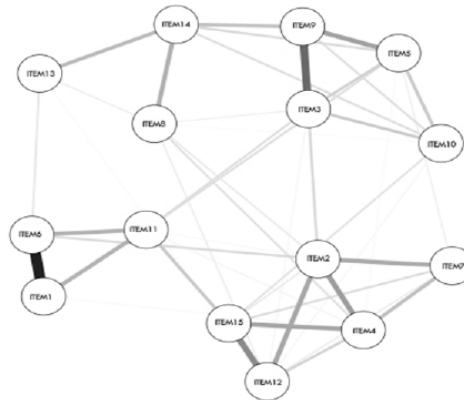


FIGURE 1. Network Analysis: The relationships among the IGRS - 15s items and scales.

We also performed a rank percentiles division to see the distribution of the levels of the different kinds of guilt (see Table 3).

The test-retest reliability, assessed after four weeks on a random sample of 47 subjects, was as follows: Survivor guilt  $r = .74$  ( $SD .001$ ); Omnipotence guilt  $r = .64$  ( $p < .001$ ); Self-hater =  $.75$  ( $SD .001$ ).

*Guilt and Socio-Demographic Variables.* In line with our hypotheses, a Mann-Whitney U-test revealed gender differences for Omnipotence guilt, which was stronger in females than in males [2.44 ( $SD = .66$ ) vs 2.58 ( $SD = .63$ );  $U = 20991.5$ ;  $p = .027$ ]. Survivor guilt also was higher in women, but this difference was significant only at  $p = .065$  [2.38 ( $SD = .86$ ) vs 2.87 ( $SD = .80$ );  $U = 20804.5$ ]

We found higher values for Omnipotence [2.65 ( $SD = .69$ ) vs 2.45 ( $SD = .61$ );  $U = 19473.5$ ;  $p = .003$ ] and Self-hate [1.80 ( $SD = .87$ ) vs 1.55 ( $SD = .70$ );  $U = 19373.5$ ;  $p = .004$ ] guilt in people who were in treatment compared with those who were not. There was also a higher level of Survivor guilt in our treatment subsample compared with the level of Survivor guilt of people not in treatment [2.39 ( $SD = .86$ ) vs 2.23 ( $SD = .80$ );  $U = 20804.5$ ] but this difference was significant only at  $p = .065$ .

No other socio-demographic variable correlated with the IGRS-15s scales. Again, these data are in line with our hypotheses.

*Guilt and Social Desirability.* Neither Survivor nor Omnipotence guilt was correlated with the Marlowe-Crowne Social Desirability Scale, although we did find a small negative correlation between Self-hate and social desirability  $r = -.22$  ( $SD .05$ ).

*Construct validity.* We examined correlations between the IGRS-15s and a measure of shame, the OAS, validated on an Italian sample. Given that according to CMT (Weiss, 1993, pp. 42-43) interpersonal guilt (as assessed by our tool) supports and strengthens feelings of chronic shame, we expected to observe moderate levels of correlation between IGRS-15s scores and OAS scores. The correlations between the IGRS-15s and the OAS are reported in Table 4.

We also examined correlations between the IGRS-15s and measures of self-esteem (the SES) and empathy (the BES). The results are shown in Table 5.

We then looked at correlations between the IGRS-15s and the scale of mental health of the SF12 (MCS). The correlation between Survivor guilt and the MCS was  $r = -.212$  ( $SD .001$ ); the correlation between Omnipotence guilt and the MCS was  $r = -.251$  ( $SD .001$ ); and the correlation between Self-hate and the MCS was  $-.364$  ( $SD .001$ ).

A further finding, which supports our hypotheses, is that Survivor guilt and Self-hate correlated negatively with therapeutic alliance (see Table 6). In particular, Survivor guilt was negatively related to the Task and Goal components of alliance, while Self-hate was negatively related to the Task and Bond components.

Given the non-normal distribution of our sample, we performed a Mann-Whitney U-test to see whether there were differences in feeling guilty between people who reported having been victims of traumatic experiences during their childhood, assessed using the Socio-Demographic Schedule, and people who did not (see Table 7).

As expected, we found a higher level of Self-hate in people who were emotionally, physically, or sexually abused in childhood [1.84 ( $SD = .88$ ) vs 1.53 ( $SD = .68$ );  $U = 22522.000$ ;  $SD .000$ ].

We also found a higher level of Self-hate [1.87 ( $SD = .81$ ) vs 1.58 ( $SD = .75$ );  $U = 11969.000$ ;  $p = .000$ ] in subjects who reported having been neglected during childhood and those who thought that their parents felt burdened by the necessity of taking care of them [1.83 ( $SD = .81$ ) vs 1.44 ( $SD = .68$ )]. Moreover, subjects reporting having felt they were a burden on their caregivers also reported higher levels of Survivor

Table 3. Percentile Ranks of IGRS-15s Subscales

	25th percentile	50th percentile	75th percentile
Survivor	1.6	2.2	2.8
Omnipotence	2.2	2.6	3.0
Self-hate	1.0	1.3	2.0

Based on means of the items (1 = low; 5 = high)

Table 4. Correlations Between IGRS-15s and the OAS Subscales

	Inferiority	Emptiness	Mistake	Total Shame
Survivor	.400**	.280**	.233**	.360**
Omnipotence	.365**	.351**	.314**	.394**
Self-hate	.588**	.407**	.442**	.570**

\*\* $p < .01$

Table 5. Correlations Between IGRS-15s and SES and BES Scales

	Self Esteem	Cognitive Empathy	Affective Empathy	Total Empathy
Survivor	-.404**	.034	.173**	.146*
Omnipotence	-.317**	.140**	.352**	.338**
Self-hate	-.623**	-.074	.054	-.006

\* $p < .05$ ; \*\* $p < .01$

Table 6. Correlations Between IGRS-15s and the WAI-S Subscales

	Task	Bond	Goal	WAI Total
Survivor	-.183*	-.137	-.178*	-.172*
Omnipotence	.007	.008	.119	-.001
Self-hate	-.216***	-.261***	-.132	-.209*

\* $p < .06$ ; \*\* $p < .05$ ; \*\*\* $p < .01$

Table 7. Traumas and Guilt

	Survivor guilt	Omnipotence guilt	Self-hate guilt
Abuse			X
Neglect			X
Burdened parents	X		X
Parents with emotional problems	X	X	X
Parents needing cares	X	X	X
Parents hurt by distance or differentiation	X	X	X

guilt [2.38 ( $SD = .83$ ) vs 2.17 ( $SD = .81$ );  $U = 21147.000$ ;  $p = .004$ ]. The presence of a higher level of Omnipotence guilt [2.58 ( $SD = .66$ ) vs 2.46 ( $SD = .63$ );  $U = 22422.000$ ;  $p = .054$ .] in people who felt they had been a burden on their caregivers tended to significance ( $p = .054$ ).

As expected, we found a higher level of Omnipotence guilt [2.61 ( $SD = .64$ ) vs 2.42 ( $SD = .63$ );  $U = 20494.000$ ;  $p = .002$ ] and Survivor guilt [2.34 ( $SD = .79$ ) vs 2.20 ( $SD = .86$ );  $U = 21761.000$ ;  $p = .026$ ] in subjects who felt that their parents had *more emotional and concrete problems than they themselves did*. Also, Self-hate rates higher in these subjects [1.77 ( $SD = .78$ ) vs 1.48 ( $SD = .73$ );  $U = 18617.000$ ;  $p = .000$ ].

And again, as expected, we found a higher level of Omnipotence guilt in people [2.67 ( $SD = .68$ ) vs 2.39 ( $SD = .58$ );  $U = 16407.000$ ;  $SD .000$ ] who were asked to or thought they had a duty to take care of their parents; in these people, we also found higher levels of Survivor guilt [2.39 ( $SD = .82$ ) vs 2.19 ( $SD = .82$ );  $U = 21160.000$ ;  $p = .007$ ]. Differences in Self-hate between these subsamples were significant too. [1.71 ( $SD = .77$ ) vs 1.58 ( $SD = .77$ );  $U = 22286.000$ ;  $p = .058$ .]

Finally, in line with our hypotheses, we found a higher level of Omnipotence guilt [2.64 ( $SD = .66$ ) vs 2.42 ( $SD = .61$ );  $U = 20239.000$ ;  $p = .001$ ] and Survivor guilt [2.43 ( $SD = .82$ ) vs 2.14 ( $SD = .81$ );  $U = 19874.500$ ;  $SD .000$ ] in people who felt that their parents suffered because of their physical distance or differences in opinions, choices, and values. Self-hate was also higher in these subjects [1.78 ( $SD = .83$ ) vs 1.51 ( $SD = .70$ );  $U = 19681.000$ ;  $SD .000$ ].

We performed all the analyses separately on the clinical and non-clinical subsamples, and the results were substantially overlapping. (For more information, the interested reader should write to the second author of this article))

## Discussion

On the basis of the analyses conducted on this sample, we were able to confirm the previously established factor structure of our measure, which differentiates Survivor guilt, Omnipotence guilt (which comprises separation/disloyalty and omnipotent responsibility guilt items), and Self-hate. This result supports the idea that people are not able to clearly differentiate whether they feel guilty because they feel they are always able to and must always take care of other people (omnipotent responsibility guilt), or because they feel that *separating and becoming independent themselves hurts* the people they love (separation/disloyalty guilt). We labeled the factor "Omnipotence guilt" because it describes two domains of guilt that show how people who are particularly affect-

ed by this kind of guilt tend to attribute to themselves excessive power in determining the well-being or suffering of the people they love.

In line with the results of previous studies (e.g., Torstveit, Sütterlin & Lugo, 2016), we found higher levels of guilt in females than in males. We believe that this may be because females tend to be more empathic than men, which is true in this sample too. [Cognitive empathy: 3.89 ( $SD = .474$ ) vs 4.09 ( $SD = .513$ ),  $F = 17.741$ ,  $SD .001$ ; affective empathy: 3.497 ( $SD = .557$ ) vs 3.195 ( $SD = .450$ ),  $F = 61.376$ ,  $SD .001$ ; total empathy: 3.676 ( $SD = .415$ ) vs 3.998 ( $SD = .450$ ),  $F = 57.87$ ,  $SD .001$ ]

In line with our expectations, two of the three IGRS-15s factors (Survivor guilt and Omnipotence guilt) showed no correlation with social desirability, while Self-hate correlated negatively with this construct. This latter finding could be interpreted as a consequence of the fact that Self-hate describes an extremely negative image of oneself, which is also reflected in how people affected by this kind of guilt describe themselves through the MCSD's items.

Moreover, the correlations between affective empathy and both Survivor guilt and Omnipotence guilt are in line with the construct of interpersonal guilt as conceived in CMT and our hypotheses; however, we also found a positive correlation between Omnipotence guilt and cognitive empathy, which could be interpreted as resulting from the fact that people affected by this guilt try to understand as deeply as possible the perspective of others.

The fact that scores on all the IGRS-15s factors were higher for people in treatment than in those not (actually, the higher level of Survivor guilt in the clinical population only tended to significance) suggests that guilt can be a powerful component of psychological suffering. Indeed, in line with this hypothesis, we found that all the kinds of guilt assessed by the IGRS-15s correlated positively with shame and negatively with self-esteem and mental health.

As expected, then, Survivor guilt and Self-hate correlated negatively with self-reported therapeutic alliance: People who feel guilty for being or feeling better off than other people and believe they do not to deserve to be happy have difficulties in establishing a good working relationship with their therapist. In particular, Survivor guilt prevents them from performing the Tasks necessary for a good therapeutic outcome and have difficulty committing to the pursuit of therapeutic Goals; while Self-hate negatively affects their ability to create a good enough Bond with the therapist and perform the Tasks necessary for the success of the therapy.

Finally, our findings on the relationships between the various kinds of self-reported trauma and the different kinds of guilt assessed with the IGRS-15s support the CMT hypotheses: People who self-reported

having parents who exhibited more problems than they did themselves, who asked them to take care of them, and/or who showed being hurt by their separation and differentiation showed higher levels of Omnipotence guilt and Survivor guilt. In other words, they tended to believe that they had to take care and/or remain close to the people they loved as though they were responsible for their well-being, and felt guilty if they believed they were or felt better than other people. Moreover, people who were sexually or physically abused or neglected, and/or who felt that their caregivers were burdened by their care needs, showed a higher level of Self-hate, as though they felt that they deserved the treatment they received.

However, in our opinion the more interesting result that we have found is the fact that virtually all the kinds of trauma investigated in this study were associated with higher levels of Self-hate. In our opinion, this data could be interpreted as evidence that children may develop a certain degree of Self-hate whenever they feel that their caregivers are unable to understand what they feel or give them what they need with love. As pointed out by Weiss (1993, p. 30), children, in fact, tend to think that they deserve the way parents treat them.

Overall, our data support the constructs of the different kinds of guilt as conceptualized in CMT and assessed with the IGRS-15s: Survivor guilt and Omnipotence guilt—which in a previous study (Gazzillo et al., 2018) were found to be connected to the basic affective systems of care, attachment, and fear—were connected to the empathy felt for other people's suffering, contributed to feelings of shame and low self-esteem, negatively affected well-being and mental health, and were stronger in people who felt that during their development their caregiver had more problems than they did, needed their help, or appeared burdened by them or pained by their separation and differentiation. Self-hate, for its part—which the same previous study showed to be connected to attachment and fear motivational systems but not to the care system—was not correlated with empathy, negatively affected self-esteem, well-being, and mental health, stirred up feelings of shame, and negatively influenced therapeutic alliance, as did Survivor guilt. Finally, it is worth noting that Self-hate appears to be a virtually ubiquitous consequence of a traumatic past.

## LIMITATIONS AND FUTURE DIRECTIONS

The first limitation of this study is the fact that it is based on a self-report measure intended to assess interpersonal guilt, a construct which, according to the literature, may often be implicit/unconscious (e.g.,



Bush, 2005). On the one hand, using self-report tools simplifies data collection, in particular in non-clinical samples; on the other, self-report instruments are not the best tool for assessing unconscious/implicit dimensions of mental functioning, as reported many times in the literature (e.g. Shedler & Westen, 1998; Westen & Weinberger, 2004). And this is the main reason why we developed a clinician-report version of our IGRS-15 (Gazzillo et al., 2017).

A similar problem, in our opinion, is connected to the self-report assessment of traumatic experiences in childhood. In this study, we simply asked participants whether during their childhood they felt/thought they had been victims of emotional, sexual, or physical abuse or neglect; whether their family members had more emotional or material problems than they did themselves; their family members had found it difficult to accept their autonomy and differences of opinions; their family members had difficulty taking care of them; or their caregivers had asked them to be their caregivers (role-reversal). We are aware of the fact that people are sometimes unable to remember or report events such as these or may not be completely aware of their trauma, for example, because they have never experienced other, better relationships. Moreover, longitudinal studies are needed in order to show whether there is a causal relationship between experiencing these types of traumas and developing the various kinds of guilt measured by the IGRS-15s. However, the differences in guilt levels observed between people who had suffered these different traumas and those who did not were clearly consistent with our hypotheses and CMT-driven assumptions.

In terms of the items of our tool, only one (item 13) showed a loading slightly lower than .30. Nevertheless, we decided not to delete it because it assesses a relevant aspect of Omnipotence guilt. In future studies, we will reword it and check whether the rewording affects its factor loading.

Another limitation of this study is that it did not give us reliable information for developing empirically sound thresholds for differentiating clinically meaningful levels of guilt. A next step will be to collect data aimed at establishing such thresholds.

A further dimension we will investigate in future studies is the relationships between the kinds of guilt assessed by the IGRS-15s and different psychopathologies.

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## APPENDIX

The Interpersonal Guilt Rating Scale-15s  
(IGRS-15s)

1	2	3	4	5
Not representative at all	Not very representative	Representative enough	Very representative	Completely representative
1	I believe that if other people really knew me, they would want nothing to do with me.			1 2 3 4 5
2	I feel uncomfortable feeling better off than other people.			1 2 3 4 5
3	I feel it is my responsibility to fix other people's problems.			1 2 3 4 5
4	I feel uncomfortable when I believe that I am better than others.			1 2 3 4 5
5	I feel selfish and insensitive if I am not the person who takes care of other people.			1 2 3 4 5
6	I believe I have tricked other people into liking me.			1 2 3 4 5
7	The idea of being envied makes me acutely uncomfortable.			1 2 3 4 5
8	I feel I should visit my parents as often as they wish.			1 2 3 4 5
9	I feel overly responsible for other people's well-being.			1 2 3 4 5
10	I tend to put aside my interests, needs, and passions to take care of other people.			1 2 3 4 5
11	I do not deserve to be happy.			1 2 3 4 5
12	I conceal or minimize my successes out of concern for making less successful people feel bad.			1 2 3 4 5
13	I would feel badly if I doubted the values and beliefs of my family			1 2 3 4 5
14	I do not think I should separate from loved ones because this would be hurtful, disloyal, or make them feel abandoned.			1 2 3 4 5
15	I feel uncomfortable when I receive better treatment than others do.			1 2 3 4 5