erford, and Nichols. We have also included the late Lloyd Silverman's discussion of earlier versions of these papers in a symposium at the 1984 meeting of the American Psychological Association; Silverman provided a unique slant by applying his research on subliminal perception to the theoretical debate and clinical material. These critical discussions stimulated further elaboration and clarification of the theoretical issues and clinical material as Bush replies to Horwitz and Weatherford replies to Silverman.

Using what has become widely employed terminology, the authors throughout refer predominantly to unconscious and irrational *guilt.* Although we have acceded to this common usage, Karl Menninger has drawn our attention to the fact that "unconscious guilt" is a misnomer; true guilt requires a preceding wrong *action,* but how can there be a misdeed of which the wrongdoer is unaware? To distinguish guilt from guilt feelings is not mere editorial nit-picking; it is a necessary clarification. At issue are guilt *feelings* that arise in the context of *innocence.* But in focusing on guilt feelings we should not lose sight of guilt. As Karl Menninger demonstrated in *Whatever Became of Sin?,* guilt pervades our lives as much as guilt feelings. If psychotherapy cannot expunge guilt, should it eradicate guilt feelings? Or redirect them? Freud offered modestly to transform neurotic misery into "common unhappiness"; perhaps as a result of psychotherapy, irrational guilt feelings can only give way to a well-founded sense of guilt.

As Horwitz and Silverman attest, the work of the Mount Zion group has contributed much by alerting psychotherapists to the cardinal role of guilt feelings in patients' symptoms and in the psychotherapy process. The aim of this topical issue is to refine and sharpen this theoretical contribution. The greatest strength of the Mount Zion approach, however, lies in the commitment to testing the validity of the theory and the effectiveness of the therapeutic approach by means of systematic research. These clinicians are not only put to the test by their patients; they put themselves to the test. Perhaps some of the theoretical issues debated here will also be put to the test.

The Role of Unconscious Guilt in Psychopathology and Psychotherapy*

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Abstract: Using a new psychoanalytic perspective, the author explains how irrational unconscious guilt originates, how it produces psychopathology, and how it is mastered in psychotherapy. According to this perspective, unconscious guilt is a product of repressed irrational beliefs derived from traumatic childhood experiences. The author emphasizes the role of guilt as a source of resistance and transference, and he explains patients' unconscious efforts to master problems with guilt through an ongoing process of testing the therapist. Therapeutic outcome significantly depends on the degree to which therapists pass patients' tests and accurately analyze patients' guilt-based resistances and transferences. The author briefly describes an empirical study based on these concepts. (*Bulletin of the Menninger Clinic, 53,* 97–107)

Joseph Weiss has developed a new psychoanalytic theory that assigns a key role in the development of psychopathology to "grim unconscious beliefs" (Weiss & Sampson, 1986, p. 6) arising from traumatic childhood experiences. Weiss and Harold Sampson, in collaboration with the Mount Zion Psychotherapy Research Group, have been conducting an ongoing series of scientific investigations of this theory. Their initial studies of a completed analysis are reported in their 1986 book. Weiss's theory incorporates the increasing emphasis that Freud, in his later writings, gave to the role of irrational unconscious guilt as a determinant of neurotic suffering and the "negative therapeutic reaction" (1923/1961a, 1924/1961b, 1926/1959, 1928/1961c, 1930/1961d, 1933/1964).

Unconscious guilt is an extremely powerful force in human development and behavior that manifests itself in a much wider variety of ways than Freud originally recognized. It plays a primary causal role in most, if not all, forms

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of psychopathology and is capable of producing the most painful and crippling inhibitions, symptoms, and maladaptive character traits. Of the various determinants that may contribute to a pathological behavior pattern, irrational unconscious guilt is often the most significant. Because guilt and defenses against it manifest themselves in such diverse and unexpected ways, the significance of unconscious guilt as a determinant of psychopathology and its role in the therapeutic process are often misunderstood, underestimated, or overlooked.

In this paper, I will discuss a number of interrelated ideas about the role of irrational unconscious guilt as a primary cause of psychopathology and as a primary determinant of patients' resistances and transferences in psychotherapy. I will focus on (1) the relation of unconscious guilt to irrational unconscious beliefs about how one has harmed or may harm significant others, (2) the patient's unconscious efforts to master guilt problems in psychotherapy, and (3) how the therapist can best assist the patient in those efforts. Finally, I will briefly describe an investigation that used these ideas to predict a patient's reactions to an analyst's termination interventions.

A Clinically Useful Model

The conceptualization of guilt elucidated here is based on what we believe to be the most clinically useful approach to treating patients. According to this model, irrational unconscious guilt stems from distorted unconscious beliefs about having done something bad in the fundamental sense of doing something hurtful or being disloyal to another person toward whom one feels a special sense of attachment or responsibility, such as a parent, sibling, or child.

Our model of guilt emphasizes the primacy of the individual's fear of hurting others as the deepest unconscious layer of the experience of guilt. Rather than seeing the nucleus and genetic origin of unconscious guilt primarily in terms of an internalized fear of punishment by the castrating oedipal parent, which is the traditional psychoanalytic position, we believe that the most debilitating types of unconscious guilt stem primarily from irrational beliefs about how one has harmed one's parents and siblings.

We differ with classical psychoanalytic theory in another respect: We do not consider the intensity of a person's unconscious guilt invariably to be a function of the strength of that person's unconscious hostile or incestuous wishes. People tend to feel guilty about any harm they think they have caused a loved one, whether that harm was unconsciously wished for or not. Moreover, people with intense unconscious guilt often falsely assume that they harbor evil intentions and may therefore accept untrue negative interpretations of their underlying motivations. This situation applies especially to therapy patients. Thus, rather than assuming that unconscious guilt is justified by one's unconscious motives, we assume that the way people view their unconscious motives is significantly influenced by the intensity of their irrational guilt.

The experience of guilt, or just the threat of it, produces anxiety and elicits powerful defenses, because guilt is one of the most dangerous of human emotions. In addition to their potential for becoming unbearably painful, guilt feelings increase a person's vulnerability to being traumatized because they destroy self-esteem and self-confidence, create a predisposition to accept false accusations and undeserved mistreatment, and produce a need to incur punishment and make restitution. Unconscious efforts at restitution are often based on the magical idea that the suffering of another person can be alleviated or redressed by submitting to the injured person's wishes or by inflicting an analogous type of suffering on oneself. The particular form that efforts at self-punishment and restitution take will be determined largely by the punishments an individual experienced as a child, the behaviors that seemed effective in restoring other family members, and the unconscious beliefs about the nature of the harm one has inflicted on someone else. In extreme instances, unconscious guilt may drive people to suicide or to such extraordinary degrees of submissiveness and compliance that they sacrifice their individuality, their sense of reality, or their sense of self.

For all the foregoing reasons, a person's unconscious defenses serve to reduce, avoid, and repress the experience of guilt. Freud (1926/1959) noted in his formulation of the signal theory of anxiety that neurotic symptoms and inhibitions function to remove an individual from a situation of danger. The experience of guilt is one of the most compelling internal dangers that symptoms, inhibitions, and pathological character traits are intended to avoid. Although an individual's guilt feelings may be deeply repressed and strongly denied, they unconsciously exert the most far-reaching influence on other areas of personality functioning. It is not unusual for a patient's life to be totally dominated by irrational guilt without the patient being aware of its existence, its origins, and its pathological effects.

Origins of Unconscious Guilt

Just as anxiety is a primary reaction to a traumatic experience, guilt is a primary reaction to believing that one has subjected a significant other to a

traumatic experience. Analogous to signal anxiety, "signal guilt" (Kris, 1976; Loewenstein, 1972/1982) is an anticipatory warning reaction to an unconscious perception that one is in danger of hurting someone else, and it initiates defensive and restitutional activity to avoid that danger.

Irrational guilt arises because children make false causal connections between their own behavior and harmful things that happen to them and other family members. For a variety of reasons, children are prone to develop exaggerated and distorted conceptions of how their behavior has hurt or may hurt others. Because children have only a limited understanding of accurate causal relationships and are egocentric, omnipotent, and magical in their thinking, they are inclined to blame themselves and to feel responsible for anything bad that happens to their parents, their siblings, and themselves.

Children often blame themselves for mistreatment they experience at the hands of their parents because they have a strong need to love, trust, and depend on their parents, and to feel loved and protected by them. It is therefore difficult for children to attribute malevolent motives to their parents. They rely on their parents to help them interpret inner and outer reality, and they tend to accept parental misinterpretations of their motivations. Therefore, if children are mistreated by their parents or are falsely accused of harboring malicious attitudes toward them, they are likely to accept the accusation and to believe that they must have done something bad or hurtful to their parents.

Children ordinarily do not know that their parents may irrationally blame, punish, abuse, reject, or neglect them because of the parents' own psychopathology. Moreover, children's protests against parental mistreatment or false accusations often elicit such hurt or angry responses that they become even more convinced of their own wrongdoing and evil intentions.

Children may blame themselves not only for any mistreatment they experience at the hands of their parents, but also for their parents' and siblings' problems, misfortunes, and unhappiness. They often respond to parental suffering by assuming that they have done something to injure their parents or that they have failed in their responsibility to make their parents happy. Although there are a variety of ways in which children may develop an irrational belief that they are responsible for someone else's problems or unhappiness, it is not unusual for parents directly or indirectly to communicate this idea.

Children develop their theories about how their behavior has been or may be hurtful to their parents and siblings from a variety of sources: They observe what seems to hurt their parents and siblings in their relationships to each other and to people outside the family; they observe what their parents or siblings do that hurt them; and they take special notice of how their parents and siblings react to different kinds of behavior on their part.

In developing their beliefs about how they hurt others, children are guided not only by what their parents say, but even more importantly by what they do. If a parent becomes withdrawn and depressed or assaultive and rejecting whenever a child develops a relationship with someone else, the child may come to believe that developing relationships outside the family hurts the parent. If that parent exhorts the child to develop closer relationships with other people, the child is likely to receive an entirely different message from what the parent is overtly saying.

Because of their intense need to maintain good relations with their parents, children may condemn as bad any wish, affect, idea, behavior, or goal that they believe could harm another family member. In this manner, a child may develop guilt about—and therefore decide to repress—not only morally reprehensible impulses (e.g., incestuous or parricidal wishes), but socially desirable motivations as well (e.g., strivings toward individuality, independence, autonomy, responsibility, integrity, mutuality, intimacy, success, mature sexuality, and happiness). Moreover, to punish themselves and make reparations to the persons they believe they have damaged, children may develop extremely abnormal behavior patterns and become pathologically antisocial, perverse, infantile, or narcissistic. Thus unconscious guilt may lead to a wide variety of severe psychological disorders that are often conceptualized in terms of structural impairments, developmental deficiencies, and basic drive disturbances.

Instinctual drives do not invariably create unconscious guilt, nor does unconscious guilt invariably produce repression of drive impulses. The relationship between the drives and unconscious guilt is mediated by unconscious beliefs about how one's drive behaviors have affected others and about how the repression, mastery, or acting out of one's infantile sexual and aggressive impulses will affect others.

Drive behaviors may become the source of intense guilt and anxiety and may therefore be repressed if the child infers that they are harmful to other family members or that they expose the child to a situation of danger. Conversely, if children infer that their attempts to control and master their instinctual impulses and to overcome their incestuous object choices are harmful to a parent or to their relationship with a parent, they may develop intense guilt and anxiety about their efforts at control and mastery, and they may seek to placate, restore, or protect the parent by abandoning those efforts.

Such a child may consequently remain infantile, impulse-ridden, or incestuously attached to the parent.

The Role of Trauma

In Weiss's theory, trauma plays a central role in the origins of unconscious guilt. Freud (1926/1959) reintroduced the centrality of trauma in the etiology of neurosis when he formulated the signal theory of anxiety. We believe that trauma plays as significant a role in the origins of unconscious guilt as it does in the origins of signal anxiety. In this discussion, I have followed Greenacre's (1967/1971) usage of the term *trauma* to describe any condition that seems "definitely unfavorable, noxious, or drastically injurious to the development of the young individual" (p. 277).

Children typically develop unrealistic theories about how they are to blame for the traumatic experiences that befall them or other family members. Those theories, although usually repressed in the course of development, unconsciously give rise to distorted conceptions of one's power to hurt others; an inner sense of wrongdoing, badness, and undeservedness; and a need to institute pathological symptoms, inhibitions, identifications, and character traits for purposes of self-punishment and making restitution.

The relationship between trauma and masochism that has been discussed in the psychoanalytic literature can best be understood in terms of problems with unconscious guilt that result from untoward childhood experiences. Traumas that befall other family members tend to produce intense unconscious survivor guilt. Traumas that befall oneself, especially those stemming from parental mistreatment and rejection, often produce a deep-seated unconscious belief that one is unworthy and deserves punishment. Massive trauma can exert a pathogenic influence and create masochistic symptomatology at any point in the life cycle.

Weiss has suggested that most inhibitions and symptoms represent either compliances to or identifications with other family members toward whom one unconsciously feels guilty. Symptoms may also represent mixtures of compliance and identification. The unconscious purpose of these compliances and identifications is to reduce guilt through a self-sacrificial restoration of or a display of loyalty to the injured party.

Resistance and Transference

Any kind of unconscious guilt is likely to become a source of resistance and transference in psychoanalytic therapy. In fact, the most difficult resistances to deal with and the most salient aspects of the transference neurosis often stem from the patient's problems with unconscious guilt. Patients worry about hurting the therapist just as they worried about hurting their parents and siblings, and they commonly develop regressive, idealizing, and sexual transferences to protect and restore the therapist. Therapists can help patients gain insight into and mastery of their guilt by consistently and thoroughly analyzing their guilt-based resistances and transferences.

Interpretation of Guilt

Freud repeatedly noted that patients have difficulty accepting and believing guilt interpretations. He suggested that patients can more readily comprehend guilt interpretations when therapists offer them in terms of the need for punishment. We believe that guilt should be analyzed in terms of the unconscious beliefs on which it is based, the genetic origin of those beliefs, and the role the patient's guilt plays in producing neurotic suffering and self-destructive behavior.

Patients may be skeptical about guilt interpretations for varied and complex reasons. They may feel too endangered at the moment by the potential consequences of having some aspect of their unconscious guilt made conscious. For example, patients may unconsciously decide that increased awareness of their guilt might tempt them to act out their self-destructive impulses or make them more vulnerable to some feared exploitation by the therapist. On the other hand, a guilt interpretation may be resisted because it is incorrect or because it is experienced as a seduction or an assault by the therapist. If a man is told that he is struggling with unconscious guilt over homosexual impulses when he is actually struggling with unconscious guilt over heterosexual or competitive wishes, he may become suspicious of the therapist's motives and be set back instead of benefiting from the interpretation. Similarly, if a woman is told that she is struggling with unconscious guilt over her envious and castrating wishes toward men when she is actually struggling with unconscious guilt over her desire to love and be loved by a man, she is not likely to benefit from such an interpretation.

The validity and therapeutic usefulness of a guilt interpretation, as with any other kind of interpretation, should be judged by the actual effect the interpretation has on the patient's subsequent behavior, not by the patient's immediate agreement or disagreement with it. Some patients are initially disturbed by direct guilt interpretations and may not benefit from them until later in therapy. Other patients will be immediately helped by them, although

they may dismiss or ridicule the therapist's guilt interpretations. Patients in crisis often derive dramatic benefits from interpretations about the role unconscious guilt plays in their reaction to the crisis. We have found, both clinically and in our research, that patients improve as they gain insight into the relationship between their unconscious guilt and their irrational feelings of responsibility for other people.

Mastering Guilt in Psychotherapy

According to Weiss's view of the therapeutic process, patients continually work to resolve their unconscious guilt by attempting to disconfirm their pathogenic beliefs and master the traumatic experiences that gave rise to those beliefs. Patients attempt to disconfirm pathogenic beliefs by repeatedly testing them in relation to the therapist. Most of a patient's testing behavior is planned and executed without conscious awareness. If the therapist's behavior passes an important test, patients begin to overcome their symptomatology and start to develop conscious insight into their unconscious pathogenic beliefs and the genetic origins of those beliefs. Such insight in turn provides increased conscious control over the influence that pathogenic beliefs have on behavior and enables the patient to reality-test those beliefs in a more refined way.

Weiss has identified two types of testing strategies based on Freud's idea that people seek to master traumatic experiences by repeating them. One testing strategy is referred to as "transferring" and the other as "turning passive into active." Any particular test may include elements of both. In the transferring strategy, patients directly test a prediction based on a pathogenic belief by carrying out a trial action to see if the predicted danger materializes. In the turning-passive-into-active strategy, patients reverse roles and do to the therapist what they themselves found traumatic as a child. The patient then uses the therapist's reaction as a basis for revising a pathogenic belief. The patient also identifies with the therapist's capacity to not be traumatized by what the patient earlier had found traumatic. In other words, patients test not only to disconfirm pathogenic beliefs, but also to use the therapist as an identification model in the process of repairing damaged self-esteem, overcoming irrational self-blame, improving reality-testing capabilities, and developing a more rational and benevolent superego.

In attempting to disconfirm the pathogenic beliefs that underlie unconscious guilt, patients generally use both types of testing strategies. On a trial basis, they repeat with the therapist the behavior patterns that they unconsciously believe were seriously damaging to other family members. If the therapist maintains neutrality and seems unharmed by such behavior, patients may realize that their perceived destructive influence on their parents and siblings was exaggerated. Patients will also reenact parental behaviors that made them feel guilty, undeserving, or worthless. If the therapist again maintains neutrality and seems undefensive, patients may begin to question the necessity for feeling guilty, humiliated, or undeserving in response to the way their parents treated them.

According to Weiss's theory, therapeutic progress may occur even when the therapist fails to understand the patient's tests or to accurately analyze the patient's unconscious pathogenic beliefs. The therapist may be guided by a different theoretical model but still inadvertently pass the patient's most critical tests. Patients will try to extract the maximum benefit from any particular therapeutic approach by adapting their testing strategies to the therapist's theory and style. The therapist may, of course, also fail important tests and thereby reinforce a pathogenic belief and intensify a patient's problems with unconscious guilt. In such cases, the patient's therapeutic progress will be set back, at least temporarily.

One of the major research hypotheses of the Mount Zion group about the therapeutic process is that patients will make progress as long as the therapist either advertently or inadvertently continues to pass their most important tests. Conversely, therapeutic retreats or stalemates will tend to follow failed tests. We believe that patients will derive even more benefit from therapy if the therapist not only passes their tests, but also accurately understands and analyzes their testing behavior, their pathogenic beliefs, and their guilt-based transferences and resistances.

Research Application

A colleague and I (Bush & Gassner, 1986) applied the preceding concepts in an empirical study of the termination phase of a recorded analysis. The patient, Mrs. C, developed a strong resistance to terminating therapy after setting an ending date. The analyst analyzed Mrs. C's resistance to termination primarily as an id resistance. His interpretations focused on her refusal to accept the ultimate frustration of her infantile wishes to acquire a penis and to win his love in the oedipal father transference.

From an intensive clinical analysis of the first 10 of the final 100 hours, we inferred that the patient's resistance to termination was primarily caused by intense separation guilt stemming from an unconscious belief that she was abandoning a weak, needy, and vulnerable father figure. Her conscious erotic

idealization of the analyst as an irreplaceable love object masked an unconscious fear that she would narcissistically injure him in the same way she believed she had injured her father by attempting to establish her separateness and independence as a child.

To test our hypothesis about the most salient unconscious determinant of Mrs. C's resistance to termination, we studied the patient's immediate reaction to 112 termination interventions taken from the final 114 hours of the analysis. One group of judges assessed the degree to which each termination intervention tended to confirm or disconfirm Mrs. C's unconscious belief in her power to hurt the analyst by separating from him. These ratings were made without knowledge of the patient's immediate response to those interventions. Another group of judges assessed the immediate shift in the patient's attitude toward termination following each intervention. These ratings were made without knowledge of the interventions.

We obtained a highly significant correlation of .43 ($p < .0001$) in the predicted direction between the mean ratings of the analyst's interventions and the mean shift scores that measured changes in Mrs. C's attitude toward termination immediately following those interventions. The results strongly support our explanation of Mrs. C's resistance to termination and provide a concrete illustration of how unconscious guilt can produce powerful resistances that manifest themselves in the form of regressive demands for infantile drive gratification.

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