

## TREATMENT OF GUILT–FEELINGS

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Having accepted, many months ago, your kind invitation to appear on this symposium, I found when I began collecting my wits to write a paper that I had nothing new to say, nor any really systematic “position” to present with regard to the treatment of guilt–feelings. I have therefore contented myself with setting down a few stray thoughts on the subject, with the hope that they may here and there be so stated as to provide a stimulus to further exploration.

I suppose that the first point at which the obvious requires explicit formulation and re-emphasis is in the distinction between *guilt* and guilt–feelings. I would not take time over this distinction were it not for the fact that I have known of concrete instances in which clergymen and secular psychotherapists suffered a major breakdown of communication, to the detriment of the patient–parishioner, mainly on account of a confusion between these two concepts. Then I discovered to my surprise that there are social scientists who are themselves unclear about the matter, and sometimes aggressively so! Hence I shall begin with a brief treatment of this distinction.

### **Guilt and Guilt–Feelings**

*Guilt* is a moral, forensic, or theological concept. It has reference to an objective relation between the acts or thoughts of a human being and a specified legal or ethical system. There are, of course, psychological components involved in applying the concept of objective guilt, because among the aspects of a person’s act or thought which are relevant in assessing his guilt are his state of information, the current clarity of his mind, the strength of his impulses, and the like. But the concept of objective guilt always involves non-psychological, non-descriptive propositions in addition to the psychological ones; it involves reference to a legal or axiological system whose semantics

include an ethical primitive such as “ought” or “right” or “good.” (Which axiological terms are to be taken as primitive, and which are to be defined in terms of these, is a technical problem for the experts, fortunately not relevant to our present discussion.)

I should like to emphasize that the objectivity of guilt as a forensic or axiological notion does not presuppose an ethical absolutism (which some of us hold, and others do not). “Guilt” is to be understood *with reference to* a specified or tacitly presupposed legal or moral system S; the status of S itself is another matter, on which therapists will disagree. The important point is that a patient’s action may be objectively guilty with regard to the system S which the patient holds, and it is possible for this to be determined apart from whether or not the patient has guilt-*feeling* or whether the therapist holds S.

Guilt-*feeling* is a psychological state; descriptive and causal talk about it can proceed without the use of any axiological terms. Secular psychotherapists commonly use the shorthand term “guilt” instead of the more correct term “guilt-*feeling*,” thereby unintentionally misleading the clergyman or patient. If a pastor is told by his parishioner that Dr. So-and-So is “taking away my guilt,” the pastor understandably begins to wonder where Dr. So-and-So acquired the power of the keys, that he can absolve people from guilt by psychotherapy. But this is merely a semantic misunderstanding. It would be desirable for secular psychotherapists to cultivate the habit of saying “guilt-*feeling*,” since that is what they mean.

We know that the correlation between guilt-*feeling* and objective guilt is very imperfect, whether the ethical system taken as criterion be that held by the patient himself, the therapist, the society, the church, or whatever. A pattern which I see fairly often, since a good deal of my therapeutic practice is with intellectuals, is one in which the patient has, so to say, “officially” repudiated a certain ethical system, in the light of which system his current actions are objectively guilty. By the mechanism of isolation he is able to talk about this in a detached manner; he says, “I have been stepping out on my wife for a year now, but in my ethical system there is nothing wrong with this.” Nevertheless he does experience guilt-*feeling*, which may either be displaced following the isolation, or persist as a vague sense of unworthiness or even danger. I would agree with Mowrer that such patients have done a job of repression on the conscience, and that part of the therapist’s task is to uncover and undo the isolation and displacement so that the patient confronts the actual psychological

situation, namely, that he *feels* guilty about his adultery although he no longer holds at a conscious, intellectual level that adultery is ethically wrong.

### **Treatment as a Form of Experimental Extinction**

The traditional psychotherapeutic strategy in regard to neurotic guilt–feeling is, of course, to proceed by uncovering methods until the impulses or events from which the guilt–feeling has been displaced are elucidated and somehow inactivated. I say “*somehow* inactivated,” because the exact nature of this healing process still remains mysterious; and, as you know, one of the long-discussed problems of classical analysis is that of the patient whose sense of guilt is so deep and pervasive that he cannot, apparently, be completely relieved of it.

From the standpoint of learning theory, one may conceptualize the working through of neurotic guilt–feeling as a process of experimental extinction. Guilt–feeling is, among other things, a form of anxiety. We know from animal data that anxiety is especially refractory to extinction, and that behavior which is controlled by anxiety as a drive and cue sometimes manifests a remarkable rigidity. At the risk of being simple-minded, we can say that the mere repetition of certain words, images, and postures hundreds of times over in the presence of a human being who does not condemn reprove or punish—who does not even express surprise or unusual interest in the guilt-laden material—should theoretically lead to extinction of the conditioned emotional response (See Shoben, 1949, p. 3). It is tempting to hypothesize that in all cases where this does *not* happen, we still deal with a displacement and that more uncovering is in order; but I do not think we are justified in concluding this on the basis of our present understanding.

In this connection there appears to be a difference between the affects of shame and guilt. Desensitization of the shame reaction by mere repetition proceeds more rapidly. The relation between shame and guilt is obscure, although I am personally inclined to agree with the Freudians that shame is somehow more intimately hooked up with urethral cluster. It is obvious from a consideration of extreme cases that guilt and shame are phenomenologically and dispositionally distinct, shame having a primarily social reference and guilt requiring a considerable internalization of norms. Situations even arise in which guilt and shame are apparently in opposition with respect to a particular action. A not uncommon example in college mental hygiene is that

of a student who comes from a rigid, pietistic background and is also accustomed to high group acceptance in his home town peer group. He finds himself out with his fraternity brothers who are drinking beer. If he joins in the drinking, he feels guilty; if he doesn't, he feels ashamed. This greater dependence of shame upon the current social input perhaps explains why neurotic shame is more rapidly dispelled by therapeutic ventilation than is guilt-feeling. I have had patients who used the words "guilt" and "shame" almost interchangeably, and have found it necessary to help them clarify the distinction at the feeling level in order to proceed. Or a patient may report that he feels no guilt about a certain matter, meaning that he does not believe he did wrong. Even if this report is accurate and not merely an intellectualization, he may nevertheless be ashamed. I agree with Theodor Reik, for example, who observes that no patient is completely free of shame in reporting on his masturbation, even though it may not be invested with ethical significance at any level. The progressive sharpening of a patient's semantics as regards the words "embarrassment," "shame," "guilt," and "guilt-feeling" seems at times to heighten his self-perceptiveness and reduce the effectiveness of defensive tactics in his reporting.

### **Role of Intellectual Clarification in Treatment**

I am aware that what I have just said may sound somewhat over-intellectualized, but I do not think that it is. While the patient usually communicates more than he can report, psychotherapy is, after all, done primarily with words; and I am sure that every therapist has noticed the heightened awareness of fleeting psychic states which is sometimes brought about by strengthening, sharpening, and diversifying the patient's emotional vocabulary. As Fenichel points out, the ideal interpretation is almost a matter of directing attention to something already available in the preconscious; as a zoology student is quite literally helped to "see" something in the microscopic field by learning a new concept and its label, so the patient is to some degree at the mercy of his linguistic habits in trying to understand himself.

In this connection we may raise the broader question of the role of intellectual clarification in the treatment of guilt-feelings. Freud's dictum that the voice of the intellect is low but persistent is perhaps being given a too restricted meaning by many contemporary psychotherapists. From the well-known facts that one cannot argue a paranoiac out of his delusions or reassure a hand-washing compulsive by sending him to lectures on bacteriology, we ought not to conclude that cognitive restructuring is worthless or even that it is feeble. I have

the impression from the current literature, and from conversations with therapists of several theoretical persuasions, that such techniques as rational discussion and conceptual clarification have begun to creep back into psychotherapy, at least at certain stages. I think we should cultivate open-mindedness on this question, and beware of accepting clichés. It is one thing to try to reason a neurotic out of an unconsciously determined symptom in the first interview. It is quite a different thing to carry on a Socratic dialogue about guilt–feeling and objective guilt during the 75th hour, when the patient has been working successfully at the feeling level and now presents a genuine cognitive problem. Surely we must admit that there *are* genuine cognitive problems in human life; and the question, “Should I feel guilty about this action?”, may, under certain circumstances, reflect a valid cognitive problem. The therapist may deal with such a problem by attempted interpretations of resistance or of unconscious material, under the illusion that he is thereby “maintaining ethical neutrality”; but actually he may be doing nothing of the kind, since *one* of the messages he communicates by rejecting the patient’s axiological concerns and interpreting them as neurotic derivatives is essentially this: “No valid, objective axiological problems exist; if you think about them, it is only because you are really concerned about something else.”

### **Influence of Therapist’s Value-System**

I must confess that I do not have any solution for this practical problem. It seems to many investigators that problems of value-orientation, life-goals, and *Weltanschauung* have come, in our time, to play an increasingly important role in the maintenance of neurosis. The secular psychotherapist is not a priest, pastor, or rabbi; most of us are not even good humanist philosophers! It is not, I need hardly say, a question of how much the secular therapist should *advise* or *reeducate* or *convert*, which we all agree he should not. The question is, to what extent should he allow the therapy to become the locus of the patient’s consideration of these high matters when he is reasonably satisfied that it is not merely an intellectual defense? I will hazard a guess that this question will receive increased attention in the next few years. A major preliminary task will be getting an empirical answer to the question, how much of his own ideology the therapist inadvertently conveys regardless of his studied neutrality. The recent work of Rosenthal (1955) is disquieting in this respect, because it showed a sizable correlation between patient improvement and amount of shift toward the therapist’s value-orientation, even in areas which had not come up for explicit discussion in the therapeutic

sessions! The study by Schrier (1953) is also relevant, although less directly.

No one who has practiced or experienced intensive psychotherapy should be surprised at this. The intimate and delicate quality of the therapeutic relationship, in which so much is communicated by the overtones of voice, tempo, and choice of words, makes it almost inevitable that the therapist's own perspective on life, including his value-system and world-picture, should percolate to a sensitive patient. If Rosenthal's work is confirmed by other investigators, I would say that we are presented with a really tough problem in moral casuistry.

As has been pointed out by several writers, a therapist who is for some reason over-anxious to appear non-judgmental may actually be experienced by the patient as rejective. Such a therapist means to communicate, "I accept you as you are, however you may think of yourself"; but what he conveys instead is, "You must be a foolish person if you are feeling guilty about these things; I, by contrast, am above all this." On the other side, consider a patient who has no religious beliefs but has learned from an outside source that the therapist does. It sometimes happens to me that such a patient expresses the idea that I must find it hard to listen objectively to what he is telling me. If this remark occurs in a context which suggests that it is a transference phenomenon, I deal with it first on that basis; but I have found it helpful at the close of the interview to inject a brief didactic exposition to the effect that I do not, to my knowledge, react any more strongly to patients' reports of their behavior now than I did when I was an atheist. I go on to say that I take it for granted that the patient does things which are objectively wrong, just as I myself do, and shall no doubt continue to do for the rest of my life. I remind him that our problem is to understand the causes of his behavior, not to evaluate it. I conclude by some explicitly theological comments to the effect that none of us is in a position to judge anyone else, and if I were to reject him as a *person* because of anything he thinks or does, I would be neither a good Christian nor a good therapist. I hope I am not deceived in my clinical impression that this usually clears the air and the issue rarely arises again. Naturally we assume that the value of such a clarification would be nil unless the therapist showed himself to be genuinely accepting of the patient by his subsequent voice, manner, and choice of words. It is unlikely that one could convey such an attitude if he did not really feel it. Religious beliefs leading to definite moral views in the therapist should not, theoretically, present

any qualitatively new problem, since *all* psychotherapists have some moral standards which they apply to themselves and others in daily life, and in terms of which certain of their patients' actions would be judged unethical if scrutinized outside of a therapeutic context.

I once supervised a VA trainee who had been reared in a rather strict, pietistic Protestant sect and had abandoned his religion in adolescence. He was consciously antireligious and anticlerical and was aware that he had some unsolved problems in the religious sector. He had in treatment a highly intellectual veteran who had been converted to the Roman Church as an adult. From time to time the patient would bring up certain guilt-laden episodes and discuss his moral dilemmas regarding them. Listening to the tapes I agreed with the trainee that the patient (a mildly obsessional character) was doing a good deal of intellectualizing. But there was also another element present which gradually became clear. The patient had picked up the trainee's own religio-ethical conflict, and he felt uneasy because of this. Several times he asked direct questions of a kind which I felt could have been either answered briefly or tactfully declared out of bounds. The trainee kept up a mixture of fencing and pussyfooting, and for several sessions things were at a standstill. In spite of his super-careful avoidance of anything which might tip his hand to the patient, the therapist's tone and choice of words had actually conveyed the idea: "You should not feel guilty because of these things; they are not wrong, it is only your religion that makes you think so. But of course I am forbidden as a therapist to attack your religion, so I shall have to get at these silly guilt-feelings indirectly. Only I hope you don't catch me at it." Finally I suggested to the trainee that, the next time he found himself in one of these shadow-boxing situations, he should say bluntly: "Look, I have an idea that we are sort of at cross-purposes. I may be wrong, and if I am you tell me so. But I have a feeling that *you* think that *I* think that the only way for you to get well is to forget your religion." The trainee, who by this time had begun feeling rather desperate, did as I suggested, practically word for word. To this interpretation the patient responded immediately and enthusiastically, "That's the *most* sensible thing you've said since I've been coming in here!" After that, the therapy began to move. I suspect that the trainee learned from this little drama that there is more than one way of being judgmental.

As I warned you at the start, this has been a somewhat meandering essay. I do not believe that I am objectively guilty on this score, since this is the best I am able to do with my assigned topic at the

moment. But I must confess that I do have a few guilt–feelings. They are, however, of rather low intensity, so I think that I shall be able to put up with them.

#### REFERENCES

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(pdf by lly March 2004)