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Guilt Experience in Patients with Obsessive-Compulsive Disorder

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Keywords
Obsessive-compulsive disorder · Guilt · Guilt-inducing scenario-based test

Abstract
Background: Clinical observations suggest that many patients with obsessive-compulsive disorder (OCD) suffer from severe feelings of guilt. These observations, which are consistent with psychoanalytic assumptions (overly strict superego), have rarely been subjected to systematic empirical investigation. Even cognitive approaches broach the issue of guilt as a facet of OCD only indirectly. The purpose of our research was to investigate whether more patients with OCD report feelings of guilt as compared to healthy controls. ***Patients and Method:*** One hundred individuals (34 males, 66 females) participated in our study. Fifty participants were OCD patients according to IDCL criteria and in stationary treatment. An additional sample of 50 participants consisted of healthy controls matched for age, gender, and job status. All participants were interviewed via Structured Clinical Interview for DSM-IV. Two scales measured proneness to guilt: (a) Trait Guilt Scale (TGS) and (b) Test of Self-Conscious Affect (TOSCA). A new guilt-inducing scenario-based test (SIT) including two scales (SIT 1, SIT 2) served the same purpose. The SIT was developed by the authors and uses scenarios derived from interviews with patients and experts. Finally, we assessed depression (Beck Depression Inventory; BDI) and obsessive compulsiveness (Yale-Brown Obsessive Compulsive Scale; Y-BOCS) in the OCD sample only. ***Results:*** Our data confirm stronger feelings of guilt among OCD patients as compared to matched controls. Patients and controls differed mostly on the TGS and the 2 SIT scales. TOSCA guilt scores did not differ reliably between patients and controls. Finally, as a side result, OCD patients reported elevated depression scores. ***Discussion:*** The results of this study suggest that feelings of guilt should receive more attention than previously in the treatment of OCD. OCD patients suffer not only from their compulsive cognitions and actions but also from feelings of guilt. Exposure therapy of OCD should be complemented by treatment components that specifically address feelings of guilt.

Schulderleben bei Zwangspatienten

Schlüsselwörter
Zwangsstörung · Schuld · Schuldinduzierender Szenarien Test

Zusammenfassung
Hintergrund: Zwangspatient(inn)en leiden, wie klinische Beobachtungen zeigen, häufig unter starker Schuld, was sich auch mit frühen psychoanalytischen Annahmen

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(übermäßig hohes Über-Ich) deckt, bis heute aber nicht spezifisch empirisch untersucht wurde. Auch aktuelle kognitionspsychologische Ansätze fokussieren auf diese emotionale Seite des Zwangsgeschehens nur indirekt. Unser Anliegen bestand daher in der Untersuchung, inwieweit Zwangspatient(inn)en ausgeprägteres Schulderleben aufweisen als Personen ohne Zwang. ***Patient(inn)en und Methode:*** 100 Proband(inn)en (34 männlich, 66 weiblich) nahmen an der Studie teil, davon 50 mit einer gesicherten, IDCL-bestätigten Diagnose Zwangsstörung während eines stationären Aufenthalts, und 50 gematchte Proband(inn)en aus der Normalbevölkerung ohne Zwang. Alle Teilnehmenden erhielten eine Untersuchung mit dem Strukturierten klinischen Interview für DSM-IV (SKID); auch wurde die Depression (Beck Depression Inventory; BDI) erhoben. Mit den Patient(inn)en wurde sodann die Yale-Brown Obsessive Compulsive Scale (Y-BOCS) durchgeführt. Zu Schuld bearbeiteten alle Teilnehmenden 2 nichtklinische Instrumente: (a) Schuldinventar, Traitvariante, und (b) Test of Self-Conscious Affect (TOSCA). Darüber hinaus wurde für diese Studie der Schuldinduzierende Szenarien Test (SIT), basierend auf vorangegangenen Interviews mit Patient(inn)en und Expert(inn)en, entwickelt (2 Skalen) und von allen Proband(inn)en bearbeitet. ***Ergebnisse:*** Die Annahme höheren Schulderlebens von Zwangspatient(inn)en wird durch die Daten gestützt. Sehr deutliche Unterschiede zwischen ihnen und den Kontrollproband(inn)en fanden sich für Schuld (Trait) und die Skalen SIT 1 und SIT 2; der Schuldwert im TOSCA war dagegen unspezifisch. Als Nebenbefund sind hohe Depressionswerte bei den Zwangspatient(inn)en zu verzeichnen. ***Diskussion:*** Durch die Befunde wird nahegelegt, dass in der Behandlung von Patient(inn)en mit einer Zwangserkrankung stärker als bisher das Schulderleben thematisiert werden sollte. Die Patient(inn)en leiden neben ihren Zwangshandlungen und -gedanken stark darunter. Leitliniengerechte Behandlung via Expositionen sollte insofern ergänzt werden um spezifische Behandlungsabschnitte zu Schuld und Schuldverarbeitung.

Introduction

Obsessive-compulsive disorders (OCD; ICD F 42.0), in which we include here "predominantly compulsive acts" (ICD F42.1) and "mixed obsessional thoughts and acts" (ICD F42.2), are distinguished by the fact that the patients [lifetime prevalence 2%; Weissmann et al., 1994; Saß et al., 1996; Dilling et al., 2006] display certain cognitive and emotional features in addition to the core symptoms. These have received more attention in recent years in studies of symptoms and treatment [Salkovskis, 1996, 1998; Salkovskis et al., 1999; Clark, 2005; Fisher and Wells, 2005; Neumann et al., 2010]. Among them are strong overestimation of dangers, excessive assumption of responsibility, overestimation of risks, doubts, dysfunctional perfectionism, as well as the belief that the thoughts themselves pose a danger. The role of emotions apart from anxiety and aversion has not been specifically addressed, although clinical observations show that patients with OCD are dealing with or suffering from pronounced feelings of guilt. To feel responsible for real or supposed damage or misconduct leads – not only in the clinical context – to feeling guilty. In the clinic or hospital, however, it is not uncommon, on the one hand, for patients to feel compelled to cogitate over a guilt-related topic again and again, "like it really was" and "how it could have been prevented" [Clark and Purdon, 1995], and, on the other hand, for everyday situations that are quite unproblematic for most people to be linked with the self-assignment of "guilt" – e.g., "I have sharp *and dangerous* scissors in my apartment." Ecker [1999] speaks here of the "tender conscience" of OCD patients, which results in constant preoccupation, self-reproaches, reassurances, rituals, and compulsive acts.

Washing and cleaning rituals, so conspicuous in OCD patients, seem to be a very old theme and to express culturally metaphorical associations. This brings to mind the phenomenon of wanting to "wash one's hands in innocence" because of misconduct, injury, and moral transgression. There are testimonies in the Old Testament [Luther's Bible, Psalm 26:6: King David prays, "I wash my hands in innocence and go about thy altar, Lord"], in the New Testament [Luther's Bible, Matthew 27:24: Pontius Pilate washes his hands in innocence], or in William Shakespeare's play Macbeth: "Will these hands ever be clean?" (Lady Macbeth after the murder of King Duncan, as she tries, in her agony, to remove supposed spots).

The first psychotherapeutic discussions of guilt as an important factor in OCD come from psychoanalytic theorizing [Freud, 1926; Lang, 1986; Comer, 2001], with the view that the development of a strict superego, caused by punitive and rigid upbringing, leads to obsession and compulsion. Those affected fend off morally questionable impulses and neutralize their overblown claims of conscience through dysfunctional compulsive rituals. However, this so-called "Übermoral" (excessive morality) could also be countered by increased latent aggressive tendencies. The latter has more recently been demonstrated in empirical-cognitive psychological approaches [Whiteside and Abramovitz, 2004; Moritz et al., 2009].

From the point of view of emotion research on guilt [Tangney, 1994, 2002; Tangney et al., 1996], it is indicative that acts or failures to act that violate a normative or moral standard are usually identifiable. They could even be just thoughts. In any case, guilt would be linked to the pursuit of reparation, atonement, and apology.

Feelings of guilt can be assumed to be a core emotion in OCD [Rachman et al., 1995; Salkovskis et al., 1998]; on the other hand, deep self-blame may also be a characteristic of patients with depression, in whom it leads to self-accusations and a feeling of worthlessness and stagnation, whereas in OCD, it leads to actions (reparations), usually dysfunctional ones or taken to a dysfunctional extent. In the treatment approach of Salkovskis et al. [1998], the focus is not on guilt, but on so-called intrusive thoughts, which are linked by patients with the belief that they are responsible for such thoughts. This feeling of responsibility is discussed and modified in systematic cognitive-behavioral therapy intervention elements, with the aim of reducing so-called neutralizing reactions (rituals and thoughts). In other studies [e.g., Rachman et al., 1995], assuming responsibility is seen as a key connection to OCD and, if neutralization is prevented by rituals and thoughts, to feelings of guilt. The authors also demonstrated that OCD patients believe the scope for their personal influence is very high, and therefore, the hurdle to their assuming responsibility for what happens is correspondingly low.

Our study sought to look more closely at the relationship between OCD and guilt. It was therefore necessary to show that patients with OCD have more severe guilt feelings than persons without OCD. Previous studies have not examined this with the use of control groups and have not specifically looked at the issue of guilt. To do so, we have to revert to proven methods of emotion psychology. An additional concern was to form a connection to OCD patients and their guilt-ridden experiential world. We wanted to use a method developed jointly with them to address the issue of guilt, in which guilt is ascertained by questioning the patient about a selection of potential everyday situations that are associated with OCD. If there are high levels of guilt among the patients compared to those without OCD, this would have implications for treatment. The guideline-based standard treatment of OCD by exposure and response prevention [Hedlund, 2005; Voderholzer, 2006; Rief et al., 2007] should in this case be supplemented by therapy components that focus on guilt and guilt processing.

Method

Subjects

One hundred subjects participated in the study, 50 patients with OCD from Schön Klinik Roseneck – Hospital for Psychosomatic and Psychotherapy, in Prien am Chiemsee, Germany, and 50 matched subjects without mental illness from a population sample from the University of Koblenz-Landau, Landau campus.

The patients at Roseneck Hospital were undergoing several weeks of inpatient treatment for their OCD in a priority program tailored to this purpose, and participated in a number of therapy components, including a group on coping with OCD [Müller-Svitak et al., 2002], and in extensive exercises on exposure and response prevention. Practicing physicians or psychotherapists made the assignments after identifying symptoms in need of inpatient treatment. Diagnosis of OCD according to the ICD was confirmed at admission to the hospital using the International Diagnostic Checklists (IDCL), Structured Clinical Interview for DSM-IV (SCID), and Yale-Brown Obsessive Compulsive Scale (Y-BOCS) (see below). Of the 50 OCD patients, 25 were diagnosed with "mixed obsessional thoughts and acts" (ICD 42.2) and 25 with "predominantly compulsive acts" (ICD 42.1).

For the control group (CG) subjects, the SCID was used to exclude a mental disorder, especially OCD. That also meant that no subject should be undergoing psychotherapeutic treatment.

The CG was matched with the patient group by age, gender, and job status. There were no statistically significant differences between the groups in terms of age, gender, education, and professional attainment (average age: patients 34 years, CG subjects 37 years; gender: patients 34 out of 50 female, CG subjects 32 out of 50 female).

Measuring Instruments

International Diagnostics Checklists

All patients were screened by the IDCL [Hiller et al., 1995] according to ICD-10, as part of the routine clinical procedure.

Structured Clinical Interview for DSM-IV

The SCID [Wittchen et al., 1997] provides for more systematic and detailed detection and diagnosis of mental disorders, as described in the Diagnostic and Statistical Manual [DSM-IV; Saß et al., 1996]. All participants, both patients and CG subjects, were interviewed via the SCID, with clinical symptoms having been excluded in the CG. One out of every two participants in the patient group also met the diagnosis of social phobia or major depression; no participant in the CG had a clinically relevant diagnosis according to DSM.

Yale-Brown Obsessive Compulsive Scale

The OCD patients (not the CG subjects) were identified via the Y-BOCS [Goodman et al., 1989a, b; Hand and Büttner-Westphal, 1991] with regard to the severity of their OCD. The scale is the international standard in the field of OCD and measures the extent of obsessional thoughts and acts. It is a semi-structured standardized interview with rating specifications by the clinical investigator (internal consistency alpha = 0.89, interrater reliability $r = 0.82$ to $r = 0.96$).

Beck Depression Inventory

The Beck Depression Inventory (BDI) [Beck et al., 1961; Hautzinger et al., 2009] is a self-rating instrument for assessing the severity of depressive symptoms (internal consistencies up to alpha = 0.95). This too is the international standard procedure for this area. It was used here to gather data on the secondary depressive problem that is often present in hospitalized patients.

State-Trait Guilt Scale

Analogous to the questionnaire structure introduced by Spielberger et al. [1970] with a state component and a separate trait component (e.g., for anxiety or anger), Albs [2018] developed an inventory for measuring guilt (State-Trait Schuldinventar [State-Trait Guilt Scale, STSI], trait version). In the trait variant composed of 13 items (internal consistency alpha = 0.92) used here, the subjects are asked to state how they feel "in general." Examples: "I cannot forgive myself for what happened," "I feel full of guilt," or "I have a guilty conscience" (with a five-step scale of possible answers). The questionnaire is not designed strictly as clinical-psychological or OCD-related, but should generally be usable by anyone.

Test of Self-Conscious Affect

The Test of Self-Conscious Affect (TOSCA) [Tangney et al., 1989, 1994; Kocherscheidt et al., 2002] derives from differential psychology and thus does not pertain specifically to OCD. Its approach is scenario-based. For each of 15 predefined scenarios, 4 statements (with a five-step scale for responses) are provided which a person in this situation typically says to himself or herself; one statement in each set is guilt-related. For the purposes of this study, the participants' sum score for these guilt statements was used. Example of a scenario: "During a game, you throw a ball. It hits a friend in the face." The guilt-related statement reads, "You would apologize and make sure your friend gets better." The score ticked for this guilt-related statement was used in our study. On the other hand, a defensive statement – not used further here – reads, "You'd think your friend should practice catching a bit more." The internal consistency of the test is satisfactory. Tangney et al. [1996] reported scores around alpha = 0.70 for several studies; in one study, alpha = 0.82 was achieved. Kocherscheidt et al. [2002] reported an internal consistency for the German version of alpha = 0.74 for students (n = 194) and alpha = 0.82 for patients (n = 127).

Guilt-Inducing Scenarios Test for OCD Patients

The OCD-specific measure of the Guilt-Inducing Scenarios Test (SIT) was newly developed for this study. Clinical interviews were conducted with 5 OCD patients on guilt-related topics that the patients described as characteristic of their problem. Thirty-three such situational themes were formulated into scenarios, loosely based on the Tangney model. The list was submitted in its complete form to the OCD patients to review it for plausibility, duplication, and wording, as well as to 5 psychotherapists who were particularly experienced in the treatment of OCD. Ten scenarios were deleted after this review. The remaining 23 scenarios were then rated by the patients in this study according to the extent to which they felt guilty in such a situation (five-step response mode). The factor analysis with oblique principal axis rotation showed 2 correlated but distinct factors, in which one scenario had to be discarded due to unsatisfactory loading characteristics. Factor 1 is "Guilt because of interpersonal responsibility and considerateness" (13 items); Factor 2 is "Guilt because of morality/norm violation and risk aversion" (9 items). Examples of items which have high loadings on Factor 1 are feelings of guilt in the following situations: "Imagine that you are refueling the car of a friend. When you want to drive off, smoke is coming out of the hood: engine damage," or "Imagine thinking critically about a person close to you," or "Imagine rejecting someone who is happy to meet you." Examples of items with high loadings on Factor 2 are guilt feelings in the following situations: "Imagine driving too fast through a housing complex. The next day you read in the newspaper that a child was run over in a hit-and-run accident in that location," or "Imagine leaving broken glass on the street," or "Imagine not washing your hands after using the toilet." The item/scale properties are good. The items' averages (min. = 1, max. = 5) ranked between 2 and 3 with two exceptions, and the differences ranked between r_{it} = 0.47 and r_{it} = 0.75. The internal consistencies were alpha = 0.91 (SIT scale 1) and alpha = 0.86 (SIT scale 2; see Appendix).

Performance

The patients were studied during their inpatient stay at Roseneck Hospital. They were evaluated upon admission with the BDI and the IDCL. They were administered the Y-BOCS within 3 days, as well as the SCID (duration 1 h). On the fourth day, they completed the research instrument on guilt, as well as the trait version of the STSI, the TOSCA, and the SIT (duration 1 h). The CG subjects were recruited by two staff members of the Psychology Institute at the University of Koblenz-Landau, Landau campus (see below).

The research project was presented to the "Science Conference" committee of Roseneck Hospital, discussed, and declared to be feasible in principle. The patients received written information about the planned study and had the opportunity for questions in the individual interview. Independently of that, the potential participants gave their written consent. They received written assurance that they could withdraw at any time without it affecting their treatment. The second author (L.M.K.) examined the patients in a therapy room at the hospital in a 1:1 setting.

The CG was recruited by the snowball principle, predominantly from among acquaintances of two student trainees and mostly from Rhineland-Palatinate and Baden-Württemberg. The subjects were assessed individually at their homes or another suitable location at two measurement points. A laptop was made available to them for the survey. The BDI and SCID were used at the first measurement point, the questionnaires at the second. The subjects received EUR 20 as an incentive and in appreciation for their participation.

Results

The Y-BOCS revealed pronounced OCD symptoms for the OCD patients (Table 1, lines 1–3), who ranked above the cutoff value of 16 for Y-BOCS/total and the cutoff values of 8 each for compulsions and obsessions [Bossert-Zaudig and Niedermeier, 2002]. The Y-BOCS was not used with the CG subjects, since the SCID had ruled out OCD problems, and only patients with such problems could achieve Y-BOCS scores above zero on the items.

For depression (Table 1, line 4), the patients obtained clinically relevant values on the BDI (BDI cutoff = 18) [Hautzinger et al., 2009], whereas the CG subjects remained in the normal range (BDI cutoff <11). The difference between the groups was statistically significant and the effect size was very large (d = 2.09).

In the core characteristics of guilt, the patients differed significantly from the CG subjects on the STSI (trait variant; Table 1, line 5), but not on the TOSCA guilt scores (Table 1, line 6). Clear group differences were found for both scales of the SIT (Table 1, lines 7 and 8).

In the internal comparison of the guilt questionnaires, we found that the "trait guilt" measurement showed the clearest difference between OCD patients and CG subjects (Table 1, column "effect size" d), followed by scale 1 on the SIT – guilt because of interpersonal responsibility and considerateness; scale 2 on the SIT – guilt because of morality/norm violation and risk aversion; and guilt score on the TOSCA.

OCD and depression or guilt and depression: High scores for OCD were associated with high scores for depression, and the Y-BOCS–BDI correlation was r = 0.31 (p < 0.05). Correlations were also found between guilt and depression. The correlation between trait guilt (STSI) and depression was r = 0.57 (p < 0.01). Slightly lower correla-

Table 1. Obsessions-compulsions, depression, and guilt in OCD patients compared to nonclinical subjects without obsessions and compulsions (n = 100)

	Characteristic	Patient group (n = 50)	Control group (n = 50)	t (df)	p	d
1	Y-BOCS[a] total	21.72 (7.60)	–	–	–	–
2	Y-BOCS[a] subscale "compulsions"	13.04 (4.74)	–	–	–	–
3	Y-BOCS[a] subscale "obsessions"	8.43 (5.84)	–	–	–	–
4	BDI[b]	29.76 (13.16)	7.54 (7.45)	10.39 (78)	**	2.09
5	STSI: trait scale	2.69 (0.93)	1.31 (0.88)	7.69 (97)	**	1.54
6	TOSCA: guilt assessment	2.99 (0.59)	2.92 (0.54)	0.63 (98)	ns	0.13
7	SIT scale 1 "interpersonal"	2.77 (1.00)	2.04 (0.76)	4.03 (98)	**	0.79
8	SIT scale 2 "morality/norm"	2.72 (0.98)	2.07 (0.84)	3.61 (98)	**	0.69

Data represented as mean (standard deviation). Lines 5–8: scale total score/item number, min. = 1, max. = 5. Y-BOCS, Yale-Brown Obsessive Compulsive Scale; BDI, Beck Depression Inventory; TOSCA, Test of Self-Conscious Affect; STSI, State Trait Guilt Scale; SIT, guilt-inducing scenarios test; ns, not significant. [a] Total cutoff = 16, cutoff subscales = 8; measured only in the patient group. [b] "Clinically significant" cutoff <18, "normal" cutoff >11. ** $p < 0.01$.

tions were found between SIT 1 and BDI = 0.37 ($p < 0.01$) and SIT 2 and BDI = 0.36 ($p < 0.01$; there was no correlation between the TOSCA and the BDI).

Discussion

Our findings confirm the starting assumption of the study that patients with OCD have a substantial guilt issue in addition to compulsions and obsessions. Patients with OCD are substantially different from subjects in a CG sample who do not have an OCD problem. This applies to general cross-situational feelings of guilt, measured with the trait variant of the STSI. The high effect size of d = 1.54 also illustrates this difference. The resulting picture is qualified by the data for feelings of guilt from the TOSCA. Here there was no group difference. It remains to be determined whether this has substantive reasons or is specific to the questionnaire. As far as the TOSCA is concerned, the homogeneity for patients is alpha = 0.82 (German sample), which is why some blurring is to be expected. The questionnaire structure might also be ambiguous. This is not so much the case for the predefined scenarios, which are definitely guilt-associated according to surface impressions, but rather for the predefined answers. Both groups, patients and CG subjects, ranked in the medium-high range. The questions with guilt-related responses might have more to do with normal social behavior such as "decency" or "decorum" – namely, that one should apologize when one has done harm – than with pathological guilt and suffering.

For SIT scales 1 and 2, on the other hand, which are more strongly associated with OCD, the result already found for the general trait guilt can again be supported. The items of both scales were generated in cooperation with OCD patients. It can therefore be assumed that they describe the experiential world of OCD patients with regard to guilt in a characteristic way.

Our study thus provides evidence for previous assumptions that obsessive-compulsive patients, in addition to the cognitive components of their OCD, such as doubt, checking, overestimation of risk, assumption of responsibility, and dysfunctional beliefs [Salkovskis, 1989; Wells, 2000], also suffer considerably from feelings of guilt [Freud, 1926; Lang, 1986]. Although the cognitive components already point vaguely to guilt as a result, guilt could be deduced from that, so to speak. But if we also inquire about guilt more directly, this assumption can be further elucidated. It therefore seems advisable to ask about guilt much more directly in the clinical context. With a sharper focus on guilt – for example in therapy – self-attributions and seemingly bizarre, reparation-like compulsive rituals such as washing and continuing reassurance can be approached more specifically. This would be a clarifying component of guilt processing.

As things stand now, it can be said that the guilt issue is very pronounced. Correlations with extremely high moral standards [Van Oppen and Arntz, 1994; Bossert-Zaudig and Niedermeier, 2002] are plausible, but their genesis and development cannot yet be clarified from our data.

The OCD patients in our study otherwise presented relatively high levels of depression, as measured with the BDI. This is in line with the disease descriptions of OCD in the DSM [Saß et al., 1996, p. 482] and can also be demonstrated, here, by correlation analysis through a medium-high Y-BOCS–BDI correlation. OCD patients should, if mentally focused on guilt, have high scores on the BDI because, among other reasons, 3 of the 21 item blocks are about guilt. It is generally difficult to recruit patients with OCD in a clinical context if there is no comorbid depres-

sion [Neumann et al., 2010], since brooding, doubting, and rumination are also part of the disorder of OCD patients. Our findings underline the importance of co-detection of depression. Nevertheless, depression is not at the core of OCD, which comprises the OCD-specific rituals and thoughts that in turn are not found in depression without OCD symptoms.

Since it remains unclear from the present study's methodology whether the increased feeling of guilt is also the result of increased depression, a follow-up study would have to include patients with depression but without obsession or compulsion.

Conclusion

When studying patients who present with OCD, the less-studied topics of guilt feelings, assumption of responsibility, overestimation of one's own influence, sensitive moral categories, and the feeling of having to make up for harm done should be systematically evaluated and discussed. As for treatment, if there are strong indicators of the guilt issue – which in our assessment is likely to be the case in the majority of cases – this topic should be dealt with systematically. Here are some suggestions for further discussion.

Practical Suggestions

Based on all our practical clinical experience (first and second authors), it can be assumed that OCD patients will react with strong guilt feelings in some of their important triggering situations. This occurs, for example, in the exploration phase as well as in the discussion of the diagnostic instruments, noticeable, for example, when eye contact is broken off or in faltering speech and half-hearted attempts to remain on topic. This should be checked out. Inner attitudes, dysfunctional core beliefs, and previous experiences would have to be investigated. Frequently, a high moral standard that is relevant to guilt becomes apparent as well as statements about what one "must do" that reflect an exaggerated sense of responsibility. The SIT scenarios could be used here; either they already contain situations that are typical of the patient or they could serve as a prompt. And exposure sessions to be performed later in therapy should in principle always address the issue of guilt.

Specifically, one can take as a starting point an SIT scenario to which the patient personally responds. In role playing, patients can specify which "new" or "healthy" behavior they would like to express. In this way, the therapist can ascertain that the guilt feelings would affect action in the real world to the extent that the person "cannot" act, even if they really want to.

In exposure with emotion management, the OCD patient remains in the relevant situation until the feeling of guilt arises. The patient is guided therapeutically to perceive how the feeling of guilt becomes stronger (therapist: "How strong is your feeling of guilt on a scale of 10–100%?" Patient: "70%." Therapist: "What do you have to think about or how do you have to act to make it rise to 75%?" etc.). The therapist supports the patient in driving up the intensity of the feeling. The patient must remain in this state until the intensity diminishes bit by bit, and dysfunctional coping strategies, i.e., the specific compulsive behaviors, stop.

The instruction for an imaginative exercise for guilt exposure might go something like this: "Think about situation <*X, e.g., from the guilt scenarios*>. Imagine that you are in the scene. You feel the increasing impulse to do what is forbidden in this situation. Notice how your body reacts when you start to take an action. Notice that you do other forbidden things in this situation. Experience how a judge would observe your actions. Identify your sentences that express the guilt particularly well. Will movement occur? What kind?"

The goal must be reduction by at least 30 points or half of the intensity. There must be noticeable relief. It is important – as with all exposures with OCD – to agree on a cutoff time for the "new" behavior in the guilt-provoking situation.

It should also be noted that possible avoidance behaviors are investigated and discussed in the preparatory phase. Here is a selection: cognitive avoidance in the sense of "It's not really so bad, it's just an exercise"; motor avoidance, e.g., folding one's hands, no eye contact; emotional avoidance such as "gritting one's teeth and just carrying on!"; abdicating responsibility and/or reassuring oneself; taking a sedative; delaying ("Unfortunately, it's not possible today").

There must be at least 2 h available for the exposure (with considerable latitude). A hierarchy of guilt issues must first have been created. We begin with a subjective intensity of 40–50 and slowly increase it. We ask the patient about the intensity of their guilt feelings, on a scale between 10 and 100. We have the patient demonstrate again the ritual that would be performed because of the guilt and we collect all additional information (targeted questioning): "Does X have a special meaning?"

As the guilt feelings increase, there is often a lack of self-esteem. Therefore, the exposure is followed by a self-empathy unit – reduction to 30% or less is required. In this way, the OCD patients identify why it was important for them to have acted to block the feeling of guilt. Cognitive strategies complete the picture, such as cognitive distancing exercises, the exercise element "responsibility and guilt pie," a list such as "I am guilty because.../I am not guilty because...," and disputation over thoughts and assumptions.

Statement of Ethics

All patients and CG subjects received detailed written and oral information about the study, stated their willingness to participate on a consent form, and, if being a patient, received the assurance that they could withdraw at any time without detriment to the further course of therapy.

Disclosure Statement

There are no conflicts of interest.

Appendix

Skala 1: Schuld aus zwischenmenschlicher Verantwortung und Rücksichtnahme

- Stellen Sie sich vor, Sie verlassen Ihr Haus bzw. Ihre Wohnung, ohne die Tür abzuschließen.
- Stellen Sie sich vor, Sie denken kritisch über eine Ihnen nahestehende Person.
- Stellen Sie sich vor, Sie stellen Ihre Bedürfnisse vor die Bedürfnisse Ihres nächststehenden Menschen.
- Stellen Sie sich vor, Sie freuen sich über Ihren Erfolg/Sieg, obwohl andere verloren haben.
- Stellen Sie sich vor, Sie lehnen eine Einladung von Jemandem ab, der es gerne gesehen hätte, dass Sie diese annehmen.
- Stellen Sie sich vor, Sie betanken das Auto einer nahestehenden Person. Als Sie wegfahren wollen, raucht es aus der Motorhaube: Motorschaden.
- Stellen Sie sich vor, Sie können die Probleme Ihres Kindes, Ihres Partners oder engen Freundes nicht lösen.
- Stellen Sie sich vor, in einem Konflikt schlagen Sie die Tür fest zu. Dabei kommt das Türschloss zu Schaden.
- Stellen Sie sich vor, in einem Konflikt sind Sie stark erregt und schreien Ihr Gegenüber an.
- Stellen Sie sich vor, obwohl Sie in einer festen Partnerschaft sind, schauen Sie einem Mann bzw. einer Frau hinterher.
- Stellen Sie sich vor, Sie sagen Jemandem ab, der sich freut Sie zu treffen.
- Stellen Sie sich vor, Sie schneiden eine Brotscheibe ab, lassen das Messer liegen und verlassen das Zimmer. Plötzlich hören Sie einen Schrei aus diesem Raum.
- Stellen Sie sich vor, bei Ihrer Entscheidung für etwas steht Ihre Bezugsperson bzw. Ihre Eltern nicht an erster Stelle.

Skala 2: Schuld aus Moral-/Normverletzung und Risikoaversion

- Stellen Sie sich vor, Sie haben die Verantwortung für das Haus eines Freundes/einer Freundin. Als diese aus dem Urlaub zurückkommt, bekommen Sie einen Anruf, in dem Ihr Freund/Ihre Freundin erzählt, dass es reingeregnet hat.
- Stellen Sie sich vor, Sie werden in einem Laden mit leckeren Süssigkeiten eingeschlossen. Sie nutzen die Gelegenheit und probieren allles durch.
- Stellen Sie sich vor, Ihre Wertvorstellungen und Gedanken stimmen mit denen Ihres nächststehenden Menschen nicht überein.
- Stellen Sie sich vor, Sie lassen Glasscherben auf der Strasse liegen.
- Stellen Sie sich vor, Sie fahren schnell durch eine Wohnsiedlung. Am nächsten Tag lesen Sie in der Zeitung, dass in diesem Ort ein Kind überfahren und Fahrerflucht begangen wurde.
- Stellen Sie sich vor, Sie übernehmen eine Aufgabe und diese geht schief.
- Stellen Sie sich vor, Sie waschen sich nach der Toilette nicht die Hände.
- Stellen Sie sich vor, Sie setzen sich auf einen Schwerbehindertensitz, obwohl noch andere Plätze im Bus frei wären.
- Stellen Sie sich vor, Sie bringen einen Obstsalat mit ungewaschenem Obst mit zu einer Feier.

Pro Szenario wird die Beurteilungsinstruktion angefügt: „Bei der Vorstellung dieser Situation fühle ich mich schuldig: 1, 2, 3, 4, 5", wobei die Endpunkte mit 1 = gar nicht und 5 = voll und ganz markiert sind (keine Bezeichnung für die Werte 2 bis 4).

Fig. A1. Guilt-Inducing Scenarios Test (SIT).

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