



ADVANCING SCIENCE AND PROMOTING UNDERSTANDING OF TRAUMATIC STRESS

PTSD 101 Course

Transcript for: Addressing Traumatic Guilt in PTSD Treatment

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Welcome to the PTSD 101 Course on Addressing Traumatic Guilt in PTSD Treatment!

I'm Dr. Sonya Norman. I'm a psychologist and director of the PTSD Consultation Program for the National Center for PTSD. I'm also an associate professor of psychiatry at the University of California, San Diego.

This lecture, Addressing Traumatic Guilt in PTSD Treatment, has three objectives. First I will discuss the relationship between guilt and trauma and how we assess traumatic guilt and how guilt can be addressed in prolonged exposure therapy. Then Dr. Carie Rodgers will discuss how guilt can be addressed in Cognitive Processing Therapy.

I will begin by reviewing the relationship between guilt and trauma and discuss how we assess traumatic guilt.

Guilt related to traumatic events is very common following all kinds of traumas. Whether it's a combat Veteran who feels guilty because he couldn't protect his troops from getting hurt or a sexual assault survivor who feels guilty because he couldn't stop the perpetrator from raping him.

I'll give an example to illustrate the complex relationship between trauma and guilt. From Veterans, it is not unusual to hear about guilt that stems from shooting a child in the course of combat. A child is approaching an area where she wasn't supposed to be and ignoring warnings not to come any closer. The Veteran follows orders to shoot in this situation, and then presents to us with guilt over having a killed a child, often struggling to be around children now, even his own.

But, Veterans have also come to us for treatment where their traumatic event was that when faced with the same situation, they did not shoot the child. And now they are struggling just as much with the choice they made. What we hear is "She could have been strapped with a bomb. I failed in my duty, I froze, I let my unit down, I put so many lives at risk because I didn't shoot."

Hearing Veterans report both scenarios when they come for PTSD treatment brings home the ubiquity and complexity of trauma related guilt. How these young men and women had to make a decision where there was no easy answer and no right answer but now they suffer the consequences of whatever choice they made. This struggle may involve PTSD or depression symptoms, substance use, or trouble with relationships and other areas of functioning. What we hear over and over from clinicians treating PTSD is how painful and destructive trauma related guilt can be to someone's life and how challenging it can be to help a patient let go of the guilt.

The literature strongly supports what clinicians are telling us. Research has brought to light that guilt related to trauma is very common. Upwards of 40% of people with PTSD report some guilt related to their trauma. And, there is literature showing that guilt can contribute to the development and maintenance, not just of PTSD, but other posttraumatic distress and psychopathology, too, including depression and substance use. And, when guilt is present, it can exacerbate posttraumatic distress, such that people with high trauma related guilt tend to have more severe PTSD. Also, research suggests that the presence of guilt can make PTSD more challenging to treat. Dr. Edward Kubany did a study with Vietnam Veterans showing that guilt could be present even forty years after the trauma. Trauma related guilt also increases the risk of suicidal ideation among people with PTSD.

Across the literature, there are multiple definitions of guilt and how it relates to trauma. For this lecture, we define guilt as the pain and distress related to a thought such as, "I should've..." or "I shouldn't have done something." during a traumatic event.

Our model of guilt related to trauma is as follows. If someone experiences a traumatic event and feels guilty they might reflect on this thought of, "I should've...", or "I shouldn't have done something." If they reflect on the reason for the guilt, they might realize they violated a value important to them and they may make a commitment to live according to that value going forward. Also, by reflecting on what happened, they may come to realize they did the best they could in an unfathomable situation, or that there were no good options available to them. The other option is that someone might feel guilt and the distressful feelings that come with it, but avoid reflecting on the guilt or the trauma. As we know, avoidance of the trauma memory is common following trauma and is a risk factor for developing PTSD, substance use, and other problems.

So, someone might feel guilty and say "Ugh, I feel like I did something really wrong, what is it? What happened?" and, they might say, "Oh, I really didn't like how I handled that, I am going to change how I do things in the future." And, they will feel relief from the guilt and the guilt will actually have served a positive purpose in how they go forward.

But, when there is no reflection because of avoidance, they just have that horrible feeling and this thought of, "I did something wrong." and, that horrible feeling might actually be taken as evidence of "I must've done something REALLY wrong to feel this bad.", and "Wow, I did something REALLY wrong" might actually lead to feeling even worse, and create this cycle of non-adaptive guilt.

Sometimes, we even see this break out into shame, where this thought of, "I did something really bad," becomes, "I am really bad.", "I'm not loveable.", "I don't deserve to feel better because of what I did." This kind of guilt is the focus of today's lecture.

Specifically, we will first discuss how to assess guilt related to trauma. Then we will talk about therapist considerations when addressing guilt that are important regardless of the treatment model. Then we will discuss how to address guilt in Prolonged Exposure Therapy and Cognitive Processing Therapy.

The key question in regard to assessment is, “Is the person experiencing guilt?” And, those of us who do PTSD work know that often the answer is quite obvious. That, someone comes to us and they clearly feel terrible about something that happened. But, I'll give you two examples for consideration of where that might not be the case.

In my research with Veterans who have guilt related to combat, we have sometimes gotten referrals for people who, as we are assessing them, it becomes clear they do not feel guilt. For example, we will be interviewing someone who killed an enemy combatant in the course of their duty in combat, and, they will tell us, “I followed the rules of engagement. I followed my orders. Clearly, I knew this might happen when I joined the military. This is what I was trained for. I'm not thrilled it happened, but that's how it went.” And then, I wonder, “Well, why was this person sent to us?”, and, when I dig a little deeper I find that the referring provider maybe doesn't have a lot of experience with combat Veterans or PTSD. And, maybe when they heard about the Veteran's trauma they assumed, “Oh my gosh, he killed someone, there must be so much guilt there. Better send them to that guilt study.” So, it might just be good to make sure that there is actually this, “I shouldn't have done something.”, or “I should've done something.”

The other extreme is someone who is, maybe not capable of remorse because of some other psychopathology or Axis II disorder. And, that person also wouldn't be feeling guilt, even though maybe their actions would have led to guilt in most other people.

The bottom line is it's just important to make sure that the distress and the “I should have or I shouldn't have” cognitions are really their and not just our assumptions or the assumptions of another clinician.

Of course, as clinicians when we are intervening on something, it's good to measure whether change is actually happening. The Trauma Related Guilt Inventory (TRGI), developed by Edward Kubany measures guilt related to trauma. We recently did a review of its psychometric properties, and found that the scale was very well developed, and is psychometrically sound. The scale measures overall guilt, distress related to guilt, and four misperceptions common to guilt that we will talk about quite a bit today. The measure can be used pre- and post-treatment to assess if there is reduction in guilt.

The first consideration for clinicians working with trauma related guilt is to be patient. What we're seeing is sometimes guilt is slower to respond to treatment than other common trauma reactions such as fear and anxiety. And, maybe this is part of why sometimes therapists feel that guilt is very challenging to treat, because it can take a little longer.

Another consideration is to stay open and alert to understand the source of guilt, because this understanding often evolves over the course of therapy. For example, initially it might appear that someone feels guilty because they killed someone, but as you work with the patient more, you realize that really that, “I should...”, or “I shouldn't have...” is, “I shouldn't have felt that rush of pleasure when I killed someone.” The way you address “I killed someone” would be quite different from how you address “I shouldn't have enjoyed killing someone.” And, that might evolve even further into an even more nuanced, or complicated cognition that causes guilt.

Another consideration is to take an accepting, non-judgmental, empathic stance with your patient. Of course, this is something we always strive for in psychotherapy, but here we may need to attend to it even more than usual. Often, you are the first person hearing about something that someone believes means that they might be a horrible person. They are looking to see how you are going to react to hearing this. And, so, that initial reaction could really determine whether they keep working with you, and whether they work on this at all.

And, stay alert to your own presumptions about perpetration and judgment, and what it might mean. For example, take the case of a Veteran who went into a village a month after he had been part of a battle there, seemingly unprovoked, and killed civilians. You might think, "I don't know, is this person appropriate for a trauma focused treatment like PE or CPT? Maybe we shouldn't do it. Where's the trauma to this person who walked into this village and killed people."

However, before making the decision, it is important to look at the context and review the effect it's had on this person. For example, at the time of the shooting, was this person struggling with grief, anger, loss from the previous battle? Was there something that had happened in a battle that had taken place in this same village earlier, in this context of war and combat at a time in the war where the rules of engagement were very different than what they were later? Since the Veteran had shot the villagers, has he regretted his actions, has it contributed to his substance use, homelessness, inability to keep a job? All of these questions may be relevant in deciding on the appropriateness of trauma focused treatment.

I'll now talk specifically about addressing guilt related to trauma in Prolonged Exposure Therapy (PE), and then Dr. Rodgers will talk addressing guilt through Cognitive Processing Therapy (CPT).

Before turning to PE, I did want to take a moment to mention that there is a lot of interest in the field about what kinds of approaches might be best, and might be helpful to handle guilt. I know people are exploring spiritual approaches and integrated approaches. I think in the coming years as these get more attention, and more research, we will learn a lot more about additional ways that we can address guilt. Cognitive Trauma Therapy for Battered Women by Edward Kubany focuses on reducing guilt among women who have experienced partner violence. Adaptive Disclosure developed by Brett Litz and colleagues, and Trauma Informed Guilt Reduction developed by my research group, are two approaches that have some early work suggesting promising results. So, we may have additional evidence based methods down the road to address these issues.

In the meantime, prolonged exposure therapy and cognitive processing therapy have been shown to be very effective in treating PTSD, for both civilians and Veterans. And, today we will talk about ways to address guilt in these treatments.

We'll go through the core components of PE and talk about how guilt can be addressed within each of these. Specifically, we'll talk about psycho-education about PE and PTSD, common reactions to trauma, imaginal exposures, processing, and then in-vivo exposures. Normally, we would talk about in-vivo exposures before imaginal because that is the order in which they are presented in PE, but today we will talk about imaginal first.

This IS NOT to suggest that you would modify the manual in any way, and wait to start In-vivos until later. But rather, that you would start In-vivos the way you always would, by building a hierarchy of avoided items and some behavioral activation items, and have the patient start those as they normally would. But, it might not be until you get to know more about how guilt is affecting your patient's life, as you learn this information from

imaginal and processing, that it would feed back into the In-vivo hierarchy, and then you would add items related to guilt. We will talk more about this shortly.

In the psycho-education portion of PE, we review the model of PE, and how PTSD often develops because of avoidance and avoidance of processing emotions related to the memory and the trauma. Here, we can talk about how, in addition to habituation and trauma processing, repeated exposure to the trauma memory and avoided stimuli also allows for the development of an understanding of the full context of what happened.

After trauma, people who develop PTSD tend avoid thinking about the memory in enough detail to really look at the full context of what happened. They have snippets of the memory, of what they believe they did wrong, and what they wish they had done differently. But, they don't really look at the full context. And, just allowing themselves to retell the story over and over, as we do in PE, gives them that context, which can be incredibly helpful to understanding what they did, and why, and why things turned out the way they did. When people feel guilt, they tend to overestimate their role and responsibility in the negative outcome. Having a chance to remember more aspects of what happened can be extremely helpful to reducing guilt.

Next, we turn to common reactions to trauma. This is where the patient explains to us how the symptoms and associated problems of PTSD have affected his/her life. And, we help the patient understand how those symptoms and problems are common reactions to trauma, and common to PTSD.

Using common reactions is a very helpful way to help someone understand their guilt, and to learn more about their guilt. And, there are some common sources of guilt following trauma that we can help them put into context.

So, for example, Edward Kubany did some work showing some of the common sources of guilt stemming from combat. And, this might include taking part in an atrocity, or witnessing an atrocity, superman or superwoman guilt, which is this idea that, "I should've been able to save the day. I could've saved the day." Whether realistically that was possible or not.

Common sources of guilt for other traumas, just a couple of examples, in Partner Violence we might often hear "I should've left him earlier.", "I shouldn't have let my children see what happened.", and "I shouldn't have stayed and put my children at risk."

For sexual trauma we might hear "It's my fault, what happened, I shouldn't have been there, or been talking to that person."

So, within common reactions, if we hear these thoughts come up, we can help people see that these are common beliefs, and common sources of guilt, following trauma.

We'll turn now, to imaginal exposure and processing.

The first few times your patient is retelling the story during imaginal exposure, allow your patient to expand the context on their own. One of the most powerful pieces of PE can be the realizations someone comes to by just allowing themselves for the first time to go back into the memory, and look around and describe what happened. And of course, we know that what patients realize on their own can be much more powerful than insight that we hand to them.

And so, really just by retelling the story and being back in the memory, and taking in the context, the patient might realize, "You know, the choice I made had an awful outcome, but any choice I would've made that day would've had an awful outcome of some sort, and given what I knew, I did the best I could." Is that always going to happen? No. But, patience and giving someone the opportunity to benefit just from expanding the context during the retelling can really pay off.

Of course, often someone gets close, but doesn't quite get there. And, what we do during the imaginal, is we ask probing questions to help them along. These might be, "What were you thinking as this was happening?", "What were you feeling?", "What were you thinking just before you gave that order, or just before you turned that truck to the left?" The goal of the probing questions is to help them get that full context of why they made the decisions they made, or did they even have control over these decisions.

And, one thing we can be flagging as clinicians is common misperceptions that happen when there is guilt following a trauma. Again, to refer to the work of Edward Kubany, he identified four misperceptions common in posttraumatic guilt, and these are: hindsight bias, lack of justification, responsibility, and wrongdoing.

I'll go through these one by one. Hindsight bias is the idea that the outcome may have changed the perception of the event. And, we get hints of this when we hear our patient saying things like, "Oh, I knew something bad would happen.", "I knew things wouldn't turn out well."

To give one example, I worked with a Veteran who switched patrols with someone. His friend approached him and asked him to switch patrols, and he agreed. And, the friend got killed that day out on patrol. And, so when the patient came to us he was saying "I knew something bad would happen. It's my fault he died." Of course, if the friend had come back fine that day and said, "Hey, thanks for switching patrols with me." that memory would've been different, and there wouldn't have been this hindsight bias.

So, in regard to PE, what we can do in the imaginal is ask probing questions to help someone really remember why they made the choices they made. "When your friend asked you to switch patrols, what were you thinking?" And, the thought that came out was, "He's done a lot of favors to me, it's fine by me, no reason not to switch, sure." This person wasn't thinking, "Well he's probably going to die, but I'll do it." or "I'll send him out there to do so I don't." He was just really trying to help a friend.

In the processing we can really help someone bring home the point that they did not know the outcome when they made their decision. We might say, "You're telling me you knew something bad would happen. But, then you are also telling me that you really just wanted to help your friend." To try to help them see that the two do not add up.

Justification is the idea that the person had choices and made the wrong choice. "If I had done something differently, things would have turned out better." Of course, often in combat, or in other traumatic situations, there are no good options. There is no better choice that would've saved the day, at least not one that was known or available in that time or in that moment. Yet, people hold this belief, that they somehow could've made a better choice.

So, for example, with someone who was sexually assaulted, "If I had screamed, if I had made a lot of noise, things would have turned out better." And then, when we do the imaginal it comes to light that there is no one who would've heard that scream. And, that the person had threatened to kill the patient had she screamed.

And so in fact, the outcome could have been much worse, whereas, she was telling herself, "I wouldn't have gotten raped had I screamed."

And, this can often be the case, where once people are retelling the memory in detail, they realize that there was no good outcome or the choice they made may actually have been the least bad one. And certainly, in processing, we can additionally ask questions to help someone explore what would've been the outcome of other choices.

Responsibility is the idea that "I am mostly or solely responsible for the bad thing that happened." In life there is rarely anything that happens that has only one contributing factor. Generally, there is a series of contributing factors to any event. Imaginal is an opportunity for someone to take into account contributing factors other than themselves. For example, noise, chaos, gunfire, general confusion could have contributed to what happened during a traumatic event. Orders from higher ups and the consequences of not following orders may have played a role. It might be that lack of sleep could have contributed to your patient's reaction during the trauma.

So, imaginal is a chance for your patient to understand their responsibility in the context of other contributing factors, and in processing we can help them solidify their understanding of, "Wow, you said you'd barely slept in three days. How do you think that contributed to how you reacted?"

Statements that therapists should avoid are, "It's not your fault." or "You were just doing your job." Patients can find these kinds of statements very alienating. Generally, their traumatic events and their sense of responsibility is so complicated, to reduce it to "It's not your fault" often just makes them feel like we really don't understand.

Wrongdoing is judging oneself as if one had set out to do harm or do something wrong even though that may not have been the case.

Often this is pretty clear cut. In the example of someone who switched patrols as a favor to a friend, clearly the intent was not to get the friend killed.

Sometimes it can be much more complicated. Such as the example I mentioned of someone who went into a village and shot civilians. The idea of wrong doing is far more complicated, but again, we want to help the person take the context into account. To consider the anger, the grief, the loss they were experiencing. The context of war and combat. Have they suffered because of what they did, is that something that they see themselves wanting to do now? And, clearly if they are in treatment for traumatic guilt, likely they do not.

So again, we are not the judge or the jury, but we are helping the person make sense of what happened or what they did in the appropriate context.

To summarize, we can help address common misperceptions related to guilt through PE. We do this by letting someone do imaginal exposure to better understand the context of what happened during their trauma, by asking probing questions during the imaginal as needed, and by processing their imaginal with them.

We can also do some light psycho-education during the processing. Of course, we never, in PE, stop and write on the board, or do a 20 minute psycho-ed piece.—that would be a different model of therapy. But, we do sometimes throw into our discussions brief, little pieces of psycho-ed.

So, for example, a man who was sexually assaulted might say, "I had an erection.", "What does that mean?", "I must have enjoyed it.", "What does this say about me? That I enjoy being sexually assaulted?", and some light psycho-ed. around the physiology of erections, and when they occur, and that they could have absolutely nothing to do with pleasure or enjoyment can bring a lot of relief to someone.

Similarly, with combat traumas around guilt, learning about the fight, flight, or freeze response can be helpful, specifically that all animals might freeze or flee in life threatening situations. That, even the best military training, it may be impossible to override this biological response.

Just this kind of brief sentence or two about, hey, there might be some biology here that contributing to what happened may be very helpful to someone who doesn't already know that information.

Guilt may also have come to serve a function in someone's life that may make it hard to let go of the guilt, even after the person has realized that some of their beliefs about their role in their trauma were not true.

After someone has come to feel less guilt, it can be helpful to ask during processing "So, what would it feel like if you went forward feeling less guilty now that you realize you really couldn't have done anything differently?" Some of the answers I've heard to this question have included, "That would really mean I'm a monster if I don't even feel bad about this.", or "I can't do that because then I wouldn't be honoring my friend's memory.", or "The guilt is the only thing that keeps me from doing more hurtful things. It keeps me in line. I have to feel guilty or who knows what I'd be capable of?".

Clearly if someone leaves treatment still believing those things, they are not likely to feel a lot of relief from their guilt.

Here are a couple of brief videos where people articulate really nicely this kind of function of the guilt.

So, how do we take this function of the guilt and work with it within the PE model? Some of that, of course, will happen naturally in the discussions that emerge between you and your patient in the processing. Some of it can loop back into the In-vivos. For example, if someone feels that the only way they can express their love of someone who they lost is by continuing to feel guilty, you might explore with them other ways that someone expresses love for someone they've lost and these can become actions on their hierarchies. If these are actions they have been avoiding because of PTSD, they might start to engage in activities that are very meaningful to them and that also give them an alternative way to express this function that was previously served by suffering through guilt.

In this part of the lecture, we have discussed how guilt related to trauma can be addressed through prolonged exposure therapy. In summary, guilt can be treated effectively through PE.

And now Dr. Carie Rodgers will introduce herself and discuss how to address guilt with Cognitive Processing Therapy.

My name is Dr. Carie Rogers, I am a psychologist at the VA and I am currently the Associate Director of Education and Dissemination in the VA Center of Excellence for Stress and Mental Health. I am also an Associate Clinical Professor of Psychiatry at UCSD.

One of my primary roles at the VA for the past few years has been as a national trainer for the cognitive processing therapy roll out. So, I am going to talk today about that protocol specifically, and how to work with traumatic guilt within the context of CPT.

In CPT, we think about PTSD as a problem of recovery, which is a little bit different than people often think about psychiatric problems.

We introduce the symptoms of PTSD as a really normal, natural response to a very difficult and traumatic situation. We talk with our clients about how some people recover from trauma on their own, naturally, but a significant number of people have difficulty recovering after trauma. And, in this protocol, we think about that as a failure to recover.

Now, there are a couple of things that get in the way of recovery. We talk about a difficulty experiencing natural emotions after trauma, so people who avoid feeling fear, or anger, or sorrow that may have emanated directly from the trauma, often get stuck in recovery. So, one of our goals is to help people sit with their natural emotions, and allow them to dissipate. And, if they are able to do that, they often recover from PTSD.

Another place where people have difficulty with natural recovery after a trauma, though is in stuck points. Stuck points are beliefs, or interpretations, that people have about the trauma, about themselves, the world, or other people that might get in the way of their natural recovery. In CPT, we spend a lot of time talking about stuck points and, when I think about guilt and PTSD, that is my primary target when I am doing CPT.

There are a couple of different categories that stuck points fall into, in the cognitive processing therapy conceptualization.

The first kind of stuck points we call assimilated stuck points, and those are basically beliefs about the trauma that are not accurate, and not balanced, that get in the way of people recovering.

So, when I'm working with a patient who has PTSD, and I know that they are feeling guilty about the trauma, I am going to be paying a lot of attention to three specific types of stuck points. I am going to be spending a lot of my energy noticing whether they are engaging in hindsight bias.

Hindsight bias is, basically, the problem of viewing past events, in this case, the past trauma, in light of more recently acquired information. So, judging actions or decisions that people made during the event, as if they had all the information that they know now, rather than judging what happened during the event based on the available information that they had at the time. So, people will often say, "if I had just turned left instead of right, it wouldn't have happened.", as though at the time they knew what was going to happen if they turned left and they knew what was going to happen if they turned right, and that's simply not the case.

We have to make judgments about the decisions that we made based on the information at that time we made those choices. So, I'm spending a lot of time paying attention to whether that is happening.

I'm also going to be listening a lot for outcome based reasoning. So, that's the idea that there is really no randomness to events. That bad outcomes must be punished or are consequences for some sort of negative action. So, people will talk about the just world, if something bad happens to me I must have done something to deserve it. So, good things happen to good people and bad things happen to bad people, is the idea.

In the case of an assimilated stuck point, a lot of times what we see is the patient blaming him or herself in some way for the trauma, so the bad outcome of the event itself serves as evidence for the punishment so they take blame for the event even if it wasn't their fault at all. So, that's something I am going to pay a lot of attention to when I am doing cognitive processing therapy.

I am also going to be noticing whether the client that I'm working with is having a hard time distinguishing between guilt and responsibility and just randomness. So, one of the ways that I explain that when I talk with my patients is to talk about in the legal system. In the United States, we distinguish very clearly, things that are accidents, so there is no responsibility and there is no blame, between something that might be manslaughter, where somebody is responsible for an action, but they had no intention for harm to occur, and a charge maybe of first degree murder, where someone did something clearly wrong, and they intended to do something wrong, and they may have even planned to do something wrong.

One of the things that people do when they have PTSD following a trauma, is they have a hard time distinguishing between intending harm against someone, so for example murdering someone, versus being responsible for playing a role in an event, so shooting someone in combat perhaps in self-defense or part of a mission, versus something that is just completely unforeseeable. So, we spend a lot of time talking about the distinction so that people can begin to discern what they may have responsibility for, but what they may not have intended to do. So, if you pulled the trigger during combat you indeed played a role perhaps in someone's death, but perhaps that does not mean that you intended, you woke up that morning, intending to harm someone. So, those are really important distinctions to make in reducing self-blame and guilt when it's not appropriate.

Another category of stuck points we talk about in CPT are over accommodated stuck points. And, those are basically over generalizations that people make based on the trauma.

So, they take their experience during the trauma and the erroneous beliefs about that experience, and kind of paste them on their experience in the world with other people and in their thoughts about themselves. So, they may say something like "I'm a monster." or, "I'm a murderer." because, they were in combat and played a role in somebody's injury. Or "I deserve to be punished.", "I deserve to be miserable.", because, they are inferring that, if they intended to do something, they then deserve to be punished forever.

So, we are really paying a lot of attention to how people have interpreted that trauma, and then over generalized that understanding to the rest of the world.

So, let's spend a little bit of time talking about how we do that in CPT. And, one of the major tools that we use in cognitive processing therapy to help people begin to pay attention to what they're telling themselves about their traumatic experience, and the way they are interpreting that and pasting it onto their understanding of the world, themselves, and other people is to engage in a lot of Socratic dialogue.

So, there are lots of categories of Socratic questions that we use. I think the four that are laid out here on this slide are really useful major categories. They can be viewed as a hierarchy so that they build on one another.

But, it's certainly possible to shift from one category to another to go up and down throughout the therapy session. So, the acronym CARD is a really nice way to remember the major categories of Socratic questioning.

The 'C' in CARD stands for "clarifying." It includes identification of the specific context of events. So, what does the person mean by certain words? So, when somebody says, "I betrayed my friends.", or, "I murdered that person." you might want to ask, "How do you understand what 'betrayed' means?", or, "What do you mean when you say 'murder'?". Clarifying those words is really important in CPT, because we want to get as much context in place so that we can begin to challenge some of those stuck points.

We also want to take a look at the assumptions that people are making when we're doing CPT with somebody. So, these are really the foundation upon which conclusions are made. We want to be asking people, "How did you come to that idea?" That's the kind of Socratic question that we want to be asking when we're looking at assumptions.

So, probing for things like an understanding that the world should be a just place, is an example of asking questions about assumptions. If they're saying, "It was all my fault.", that may be based on this idea that if something bad happened to them, they must be at fault. So, we want to check and see what the assumptions are that they're coming into these ideas with.

We also want to take a look at real evidence. So, we want to be evaluating really the validity of the facts that support their assumptions, and their conclusions. So, that is, facts as we can agree on them that might hold up in a court of law. We want to be really assessing what people knew at the time, and what options they actually had. And, finally, we might need to be probing about deeper meaning. So, what do the thoughts mean about the patient, about themselves, and about the world? So, if they say, "I killed someone and I'm a murderer", what does that mean about how they perceive themselves in their relationships currently? What does that mean about how they behave in the world now? And, often what we're seeing, is that it really impacts how they function in the world now.

So, we want to take a look at that, and we want to begin to bring in more evidence that is contrary to some of those distorted cognitions so that they can have a more balanced understanding about what happened and about who they are and the kind of world that they live in.

This next slide has an outline of how you might do Socratic questioning with someone. The example that I have chosen here is a very typical statement that you might hear from a client that you're working with, "If I had done 'X', I could have stopped the event."

What you want to do when you work with someone specific is fill in that 'X'. So, for some people it's going to be, "If I had run faster, then I wouldn't have been caught.", or "If I had screamed, I wouldn't have been raped.", or "If I had turned left instead of right, the car wouldn't have hit me and my friend wouldn't have died." So, you want to fill in that 'X'.

But, you also want to start with more clarifying questions. So, if somebody is saying to you, "If I had done 'this' then everything would have been OK.", first you want to check and make sure that was an option at the time. We all often engage in wishful thinking when we look back on events in our life, especially. And, that happens a lot with people who are suffering from PTSD; they kind of look back on the event and try to undo it.

And, that wishful thinking comes into play because people often begin to tell themselves, "If I had done 'this', everything would be OK.". It gives them a sense of control, but it's often not actually true. So, we want to take a look at whether there were options for them to make different choices than they had at the time.

If 'X' was not actually an option, what were the options that they had? Did they have other options? Sometimes people don't have lots of options in traumatic situations. If they did have realistic, actual other options, what were those? So, go through those choices with them and think about what the possible outcomes might have been; not just fantasies.

One of the other things that people do is that they assume that if they had done one thing differently everything would be OK. And, that is not always the case and we certainly don't know that, as we can't read the future. Sometimes people don't have options in traumatic experiences, as I've said. If they simply had no other options, we need to work with them on accepting that they did what they could in the moment that they were in, that they may not have been able to stop the event. And, while that is sad, it is not something that guilt should follow.

So, the alternative thought, "I wish I could have done something different, but I couldn't have.", or "I wish I could have stopped the event, but I couldn't have.", is less likely to follow with an emotional experience of guilt than sorrow. And, sorrow is something that we can sit with and will dissipate over time.

Sometimes, the thing that people are telling themselves they could have done was actually an option. So, if it was an option we can ask them, "Well, why didn't you choose to do that?". Often, people make good decisions in the moment that they make their choices and it can be very helpful to walk people through what they knew at the time and why they made the decisions that they did.

We also, again, in this circumstance, want to remind people that, had they made a different choice, the outcome might have been worse, it might of been better and it might have been the same.

One of the things that I always caution people about when I am talking about Posttraumatic Stress Disorder and guilt, is that we don't want to make any assumptions as a clinician about what did and didn't happen to the person we're working with before we've asked.

If someone comes to you and says "I murdered innocent people", it's probably a good idea to find out whether that's accurate before we assume that it's not. Sometimes, people do bad things in difficult circumstances.

So, you want to ask more about what happened before you assume what people are telling you is a stuck point, rather than an accurate statement. If it is an accurate statement, then what we want to do in CPT is kind of "right size" it. So, ask some questions about whether the behaviors continued. How long ago did the behavior happen? How long ago did the incident happen? What was going on during the trauma? Was it a circumstance that was very unusual, and what have they done since the trauma?

So, often when we have people come in and say, "I've murdered innocent people", and perhaps they actually did, they are now telling themselves that they are a murderer, and they are horrible, and they're a monster, and they're evil, and they shouldn't be allowed to interact with anyone else, while they haven't engaged in any difficult or bad behaviors since the trauma.

So, that's not really a very balanced or accurate statement about themselves, but they continue to feel horrible and guilty to an extent that keeps them from living fuller lives, and that's not useful.

So, while we sometimes will see people who actually do perpetrate bad things, it's our goal to help them sort out responsibility and blame, and then not over-generalize from those events so they can move on and live fuller lives.

Finally, I just want to remind people that, really our treatment goals in CPT are to help the people we work with accept the reality of what happened to them.

We are not trying to paint a pretty picture about an event that was horrible and not pretty. We are not trying to have people think overly positive thoughts when those are not appropriate.

What we really want to do is help the people develop balanced, realistic beliefs about themselves, about the world, about other people, and about what happened to them so that they can accept what happened, feel their feelings about the event, and then move on.

And, when we're able to do that, that really decreases guilt, and it increases peoples' abilities to live much fuller lives.

Thank you Dr. Rodgers. As we discussed earlier guilt is very common following a traumatic experience and can interfere with recovery. Fortunately, as you will see in the following video, engaging in evidence based treatment for PTSD can help people overcome this difficult obstacle.

We hope that you have found this presentation about Guilt and PTSD to be useful. We hope that you will now have a better understanding of the kinds of guilt that people with PTSD experience and will have some new ways of addressing this guilt in therapy.

Thank you for listening to this presentation. For the latest information about PTSD you can visit our website at www.ptsd.va.gov. The video clips in this course are from AboutFace which is an online gallery of interviews with Veterans with PTSD who have turned their lives around through PTSD treatment. You can follow the link here to watch other AboutFace videos.