

Handout 10.4: Thinking Errors, Faulty Conclusions, and Cognitive Therapy for Trauma-Related Guilt

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There is growing recognition that trauma survivors' explanations of their involvement in trauma may contribute to posttrauma symptomatology and interfere with the process of recovery (1,2,3). These explanations often revolve around cognitive aspects of guilt, which is conceptualized as an unpleasant feeling accompanied by a set of interrelated beliefs about one's role in a negative event (2,4,5). My colleagues and I have identified four cognitive dimensions or components of guilt, which include (a) perceived responsibility for causing a negative outcome, (b) perceived lack of justification for actions taken, (c) perceived violation of values, and (d) a belief that one knew what was going to happen *before* the outcome was observed.

Several investigators have noted that trauma survivors tend to distort or exaggerate the importance of their roles in trauma (2,3,6), and trauma survivors repeatedly draw four kinds of faulty conclusions—each of which involves distortion of a cognitive component of guilt (2). First, many trauma survivors exaggerate the degree to which they were responsible for *causing* trauma-related outcomes. Second, many survivors think that their actions were less justified than would be indicated by objective analyses of the facts. Third, many survivors conclude that they are guilty of wrongdoing even though their intentions were consistent with their values. Fourth, trauma survivors often conclude that they “knew” what was going to happen before it was possible to “know.”

THINKING ERRORS THAT LEAD TO FAULTY CONCLUSIONS ABOUT ONE'S ROLE IN TRAUMA

We have identified fifteen thinking errors that can lead trauma survivors to draw faulty conclusions about how justified, responsible, and guilty of wrongdoing they were when the trauma occurred. Helping clients correct these thinking errors is a major focus of our structured cognitive therapy approach for treating trauma-related guilt (2,7). The fifteen thinking areas are discussed in considerable detail elsewhere (2) and will be described briefly in this article. Four of the thinking errors may contribute to faulty conclusions about causal responsibility; seven of them may contribute to faulty conclusions about justifiability for actions taken; three of them may contribute to faulty conclusions about wrongdoing; and one of the thinking errors may contribute to all of the faulty conclusions.

Faulty Conclusions About Degree of Responsibility

1. Faulty beliefs about pre-outcome knowledge caused by hindsight bias. Hindsight bias (which is akin to Monday-morning quarterbacking) occurs when knowledge about event outcomes biases or distorts beliefs about knowledge possessed before outcomes were known (2,8,9). Common among trauma survivors, hindsight-biased thinking leads many trauma survivors to believe falsely that they knew what was going to happen before it was possible to know or that they dismissed or overlooked clues or signs that “signaled” what was going to occur. Because they believe they “should have” acted on this “knowledge” to prevent some tragedy, many trauma survivors then conclude that to some extent they *caused* the tragedy. An incest survivor who believed she was partly responsible for causing her own abuse expressed insight about this thinking error when she said, “I was putting my thirty-eight-year-old mind in my twelve-year-old head.” She had been remembering herself as being smarter, at age twelve, than she was capable of being.

2. Obliviousness to totality of forces that cause traumatic events. Trauma survivors often seem to be oblivious to the fact that traumatic events often have multiple sources of causation and make no effort to assess the relative contributions of causal factors outside of themselves. For example, one Vietnam veteran who considered himself to be 98% responsible for the death of a buddy from sniper fire had completely ignored causal contributions of the enemy, other soldiers in his unit, the chain of command, the buddy himself, and politicians in the U.S. who were responsible for his being in Vietnam.

3. Equating a belief that one could have done something to prevent the traumatic event with a belief that one caused the event. Many trauma survivors mistakenly equate beliefs that they “could have prevented” a traumatic event with beliefs that they *caused* the event. Even if such individuals “could have” prevented the traumatic outcomes, it does not mean that they actually caused them. This explanation made sense to a formerly battered woman who said, “That’s for sure! I didn’t pull his fist into my face.”

4. Confusion between responsibility as accountability (e.g., one’s “job”) and responsibility as power to cause or control outcomes. Many trauma survivors think they caused negative outcomes because they equate some job or role assignment with an ability to determine outcomes. For example, one former platoon leader told me he was responsible for the deaths of men in his unit because “I didn’t do my job. I was *supposed* to keep my men alive.” He confused his social role or position (he was “in charge”) with what he was actually capable of accomplishing or causing. This thinking error may be particularly prevalent among parents who have lost children to homicide, suicide, accidents, or serious illness (10).

Faulty Conclusions About *Justification* for Actions Taken

5. Failure to recognize that different decision-making “rules” apply when time is precious than in situations that allow extended contemplation of options. During many traumatic events, brainstorming or extended evaluation of alternatives is not an available luxury, and decisions are often based on an almost automatic summarization and prioritization of options. In fact, failure to act quickly during a crisis can be very risky. For example, a person trapped in a burning building faces increasing risk for every second it takes to decide how to escape. What may seem to have been an “obviously better decision” after years of rehashing may not have been obvious at all during the stressful, precious moments available for deciding what to do during the trauma.

6. Weighing the merits of actions taken against options that only came to mind later. Sometimes, after much rehashing, survivors think of something that might have prevented a tragic outcome, *had it occurred to them during or prior to the trauma*. Pitman and his colleagues (11) described the case of a veteran who realized during therapy that he might have saved the life of a buddy during a Vietnam battle if he had only had the presence of mind to pick up a rifle belonging to one of the enemy dead. (His own weapon was out of ammunition.) However, because he did not think of this option at the time, it *did not exist* and was not available when the battle occurred. It was irrational for the veteran to weigh the merits of his actions against an “option” that first occurred to him twenty years after the battle. Hindsight bias is the mechanism that underlies this important thinking error, which sometimes results in severe self-flagellation (11).

7. Weighing the merits of actions taken against ideal or fantasy options that did not exist. Sometimes, trauma survivors evaluate or judge the goodness of their reasons for acting as they did “against idealized or fantasy choices that would have avoided the rape, prevented the beating, stopped the incest, or kept everyone safe and alive” (2). For example, many soldiers in battle find themselves in situations where their only choices are to “kill or be killed.” No matter what they choose to do, someone is going to die. Nevertheless, some veterans weigh the merits of what they did against Superman-like actions that would have produced no violence or death. They may give explanations such as “I should have thought of something. I don’t know what I could have done, but I should have thought of something.”

8. Focusing only on “good” things that might have happened had an alternative action been taken. Sometimes, trauma survivors glamorize an alternative course of action they contemplated but did not take when the trauma occurred, and they downplay or ignore likely negative consequences of the alternative course. For example, some adult incest survivors who think they were unjustified for not disclosing the abuse as a child dwell on the fact that the abuse *might have* stopped had they complained. At the same time, they may “forget” or disregard what they *believed* would have happened had they reported the abuse (e.g., that they would be blamed, hurt, or punished; that they would disrupt the family; that they would “betray” the offending family member).

9. Tendency to overlook “benefits” associated with actions taken. Sometimes, trauma survivors maintain important values by their actions during trauma and fail to realize that, had they acted otherwise, these values would have been invalidated or violated to some degree. For example, some battered women who refuse to press charges against their partners confirm or validate values (held at the time) that they should “turn the other cheek” and could “change” their partner if they would just try harder.

10. Failure to compare available options in terms of their perceived probabilities of success before outcomes were known. Sometimes, unselected courses of action that seemed to be poor choices when the trauma occurred are “recalled” as less likely to produce negative outcomes than actions taken. Instead of judging their reasons for acting as they did based on the quality or soundness of their decision making (before outcomes were known), some survivors judge their actions solely on the basis of the *outcome*. It is important for clients to know that even good decisions can (and occasionally will) turn out badly (because of laws of probability).

11. Failure to realize that acting on speculative hunches rarely pays off and occurrence of a low-probability event is not evidence that one should have “bet” on this outcome before it occurred. Trauma survivors occasionally say, in retrospect, that they should have acted on “hunches,” “intuition,” “premonitions,” or “gut feelings”—which, if acted upon, might have prevented or avoided a tragic outcome. However, people do not ordinarily act on speculative hunches because they are typically “long-shot” predictions, which experience has shown tend not to be borne out. Furthermore, occurrence of a low-probability outcome that was predicted by a hunch (e.g., “If I trade places with him, maybe something bad will happen”) is not evidence that one should have acted on the hunch.

Faulty Conclusions About Perceived *Wrongdoing*

12. Tendency to conclude wrongdoing on the basis of the outcome rather than on the basis of one’s intentions (before the outcome was known). Sometimes, trauma survivors conclude that they were guilty of wrongdoing, not because they behaved in ways inconsistent with their values, but because of an unfortunate (and unforeseeable) outcome. One client of mine was self-condemning and ashamed for asking a friend (when he was a child) to leave the beach and return with a fishing pole. (The boys had spotted a large school of fish.) On his way to get the pole, the friend fell off a rock jetty and drowned.

13. Failure to realize that strong emotional reactions are not under voluntary control (i.e., not a matter of choice or willpower). Many combat veterans experience guilt about being afraid in battle (12), and many incest survivors experience guilt because they became physically aroused during the sexual abuse. However, strong emotional reactions are not intellectual decisions or moral choices. None of the veterans *chose* to be afraid, and had they been able to make an “intellectual decision” not to be afraid, they wouldn’t

have been afraid. Similarly, children who are touched in certain ways by adults do not have conscious control over their autonomic nervous system.

14. Failure to recognize that when all available options have negative outcomes, the least bad choice is a highly moral choice. During traumatic events, individuals often confront situations in which *all* available courses of action have unfavorable consequences. Something bad is likely to happen whether a sexual assault victim fights back or does not resist, whether an incested child discloses the abuse or suffers in silence, or whether a soldier in battle shoots to kill or fires over the heads of the enemy. In all of these lose-lose or “catch-22” situations, no unambiguously good choices are available, and the “least bad” choice reflects sound moral judgment by validating an individual’s most important values. For example, by shooting “to kill,” the soldier may validate his values about the importance of his life and his buddies’ lives, and his beliefs about himself as a “patriotic and loyal” citizen.

A Thinking Error That Contributes to All of the Faulty Conclusions

15. Belief that an emotional reaction to an idea provides evidence for the idea’s validity. When an idea is associated with affect, the affect appears to give the idea a ring of “truth” or “untruth.” For example, a survivor might say, “Intellectually, I agree with you; but I still *feel* responsible” or “Deep down in my heart, I still *feel* that what I did was wrong.” The client might be told that “I *feel* responsible is not an emotion. What do you *think* you were responsible for causing?” A battered woman was tempted to reconcile with a boyfriend (who had almost killed her on several occasions) because she “*felt* sorry” for him. The woman was reminded that “how you *feel* when you think about staying away or reconciling is *not evidence* that it is in your best interests to stay away or go back.”

COGNITIVE THERAPY FOR TRAUMA-RELATED GUILT (CT-TRG)

The goal of cognitive therapy for trauma-related guilt (CT-TRG) is to help clients achieve an objective and undistorted appraisal of their role in trauma. CT-TRG has three phases: (a) assessment, (b) debriefing or imaginal exposure exercises, and (c) formal CT-TRG, which involves separate procedures for correcting thinking errors that lead to faulty conclusions associated with guilt (2). The thinking errors identified above are addressed in the context of four separate, semistructured procedures for teaching clients to distinguish what they knew “then” from what they know “now,” and for reappraising perceptions of justification, responsibility, and wrongdoing (in light of beliefs held and knowledge possessed when the trauma occurred). Space limitations here preclude an elaboration of the phases and procedures of CT-TRG, which are described in detail elsewhere (2,7,13). Clinicians interested in implementing CT-TRG are encouraged to examine these other sources.

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Published in *National Center for Post-Traumatic Stress Disorder Clinical Quarterly* (1997, 8, 6-8).
Reprinted in *Trauma Response* (1998, 4, 20-21). This article is in the public domain.