



DIVISION 56

# TRAUMA PSYCHOLOGY

AMERICAN PSYCHOLOGICAL ASSOCIATION

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## PRESIDENTIAL VOICE

### Helping to Alleviate Trauma Around the World

By Diane Castillo, PhD

Greetings fellow Division 56 members. For the four short months of

being President of the Division, I have been allowed to gain a perspective of Division and APA functioning and politics, which is quite a different angle than being a member. We have a broad membership and we face a number of issues—not all of which we agree upon. I see this as a good thing. We are a new Division, only 10 years old, and we are evolving. Many of us have come from other divisions. Others are from other organizations, such as ISTSS. Some of us are new to the trauma field. Others of us have been doing trauma work for many years. Some scientists, some practitioners, some of us are both. Our professional diversity can serve to enrich us or divide us. As difficult as some of the discussions have become regarding the PTSD guidelines, I hope we can all maintain perspective on the goals while recognizing and

accepting our diverse perspectives as we continue to grow and evolve.



Diane Castillo, PhD

Which dovetails with my initiative as President—Diversity. We all know diversity comes in many forms—ethnic, cultural, gender, and on and on. While APA is no stranger to diversity and often has led the way in recognizing and educating on diversity issues, I felt the need to raise the flag again in our context of trauma. We know it is the case

that the rate of trauma and PTSD dramatically increases for members of the non-majority group. For example, Hispanics have consistently shown the highest rates of PTSD when compared to other ethnic minority samples. Women also show higher rates of PTSD, even though men may experience more trauma events. It is important for us as trauma psychologists to have a special eye on the impact of diversity on the psychological expression of trauma

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**Complex Trauma Task Force**

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in the form of PTSD and understand how trauma is expressed. How to do this at a practical level? For our part, convention programming, including a call to action presidential address, hopefully has served to direct attention to the impact of diversity on trauma expression. Additionally, Dr. Bryann DeBeer and I are spearheading a CODAPAR grant with Divisions 22 (Rehab), 35 (women), 44 (LGBT), and 17 (Counseling) to develop a video series to train clinicians to identify the unique presentation of trauma in interviews. The videos are intended not to assess PTSD symptoms, but rather to take a step back in encouraging diverse clients to describe and divulge trauma events. Briefly, the videos consist of a transgen-

der male, African American female, a male with MS, and a Hispanic male combat Veteran. We hope to add to these 4 with individuals representing other diverse backgrounds with the hopes to publish these videos with free CEUs available. A journal and possibly a book are other potential outcomes.

Each of you as trauma professionals knows trauma and PTSD from your own diverse background and can contribute in your own corner of the world, whether it be through research or practice, in how to recognize and educate others in recognizing the impact of diversity on trauma.

## Editor's Note



Bryan T. Reuther, PsyD  
Editor-in-Chief

It's hard to believe that three years ago I was appointed as the editor of *Trauma Psychology News*. Over that period of time, I've met and worked with many brilliant people in the trauma psychology community, which has certainly left a significant impact on me. I immensely appreciate those who put their confidence in me throughout my tenure as editor, most notably Drs. Joan Cook, Beth Rom-Rymer, and Steve Gold. Special thanks to Dr. Tyson Bailey for his efforts alongside me as associate editor for much of my time working on the newsletter. It has been an honor and a privilege to serve Division 56 in this role, and I look forward to working with the division in other capacities in the future.

In this issue, we have an intriguing paper by a philosopher that discusses trauma, emotion, and neuroanatomy in the context of a philosophically inspired take on cognitive therapy. Also included is a thought-provoking piece in the student spotlight section about trauma and incarceration. We hope you enjoy the material, and remember it is not too late for you to submit for the summer preconvention issue! Let's welcome the new Editor, Dr. Jon Cleveland. With Jon, along with the rest of the stellar staff, *Trauma Psychology News* is in good hands.

## Division 56 Member Services

**Join Division 56:** [www.apa.org/divapp](http://www.apa.org/divapp)

**Renew Division 56:** APA Members, Associates, and Fellows may renew via [www.apa.org/membership/renew.aspx](http://www.apa.org/membership/renew.aspx). Professional Affiliates (professionals with no membership in APA) and Student Affiliates may renew at [www.apa.org/divapp](http://www.apa.org/divapp).

**Membership Term:** Membership is for January-December. If you apply during August-December, your membership will be applied to the following January-December.

**Website:** [www.apatraumadivision.org](http://www.apatraumadivision.org)

**Listservs:** Everyone is added to the announce listserv, [div56announce@lists.apa.org](mailto:div56announce@lists.apa.org) (where news and announcements are sent out; membership in Division 56 is required).

To join the discussion listserv, [div56@lists.apa.org](mailto:div56@lists.apa.org) (where discussion happens; membership is not required), send a note to [listserv@lists.apa.org](mailto:listserv@lists.apa.org) and type the following in the body of the note: subscribe div56

**Journal:** You can access the journal, *Psychological Trauma: Theory, Research, Practice, and Policy*, online at [www.apa.org](http://www.apa.org) via your myAPA profile. Log in with your user ID or email and password.

**Newsletter:** The newsletter is sent out on the division listservs and is available on the website at [www.apatraumadivision.org/207/division-newsletter.html](http://www.apatraumadivision.org/207/division-newsletter.html)

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# Use of Logic-Based Therapy to Encode Emotional Reasoning on the Ventromedial Prefrontal Cortex

Elliot D. Cohen, PhD  
Logic-Based Therapy Institute

The Ventromedial Prefrontal Cortex (vmPFC) of the brain has been linked to value-based decision-making and regulation of negative emotions. Further, one study of the vmPFC utilizing functional magnetic resonance imaging (fMRI) has helped to refine the nature of the reasoning process by which such activities as value-based decision-making proceed, especially in contexts involving negative emotions (Goel & Dolan, 2003). Such research suggests that a cognitive-behavioral therapeutic approach that identifies the logical structure of patients' reasoning involving emotional content may be more aligned with the way the vmPFC operates in performing the latter functions than an approach that does not directly identify such reasoning structures. Accordingly, this article suggests that a form of Rational-Emotive Behavior Therapy (REBT) known as Logic-Based Therapy (LBT), which identifies patients' emotional reasoning dispositions, may be more suitable as a cognitive-behavioral approach than traditional REBT, which identifies the causes of negative emotions. The article explores the implications of the latter hypothesis for the treatment of Posttraumatic Stress Disorder (PTSD).

## Logic-Based Versus Traditional REBT

LBT uses logic to identify patients' dispositional, irrational emotional reasoning in order to change these irrational dispositions into rational ones (Cohen, 1987, 1992, 2003, 2006, 2014, 2017). Whereas traditional REBT utilizes the ABC theory to identify patients' irrational beliefs (Ellis, 2001, 1991, 1990, 1971; Ellis & Grieger, 1977; Ross, 2006), LBT uses the valid syllogistic inference form of modus ponens (If p then q; p/∴ q) to help patients identify their dispositional emotional reasoning, that is, the reasoning patients do when they are experiencing emotions such as anxiety, depression, anger, and depression (Cohen, 2016).

## The ABC Model

The ABC model proceeds in terms of three psychological points (Ellis, 1971). For example, according to REBT's ABC Theory, the case of a patient, John, who has lost his job and is depressed because he believes he is a failure,

can be represented as follows:

- Point A: Activating event: John having lost his job.
- Point B: Belief system: I'm a failure
- Point C: behavioral and emotional Consequence: Depression

This model provides a *causal* analysis according to which A & B jointly cause C (Depression). As such, REBT identifies the patient's irrational *belief* (or set of beliefs) at point B that contributes causally to the patient's self-defeating emotion at point C (Ellis, 2001).

## The Logic-Based Model

In contrast, LBT's model provides a logical analysis in terms of the patient's *inference* having emotional content (emotional reasoning):

- Rule Premise: If I lost my job then I'm a failure
- Report Premise: I lost my job
- Conclusion: ∴ I'm a failure

The above LBT analysis is intended to capture the patient's emotional reasoning (Cohen, 2016), that is, the inference the patient is disposed to make when the patient is depressed. The rule premise formulates the inference rule that the patient uses to validate the inference. This conditional rule consists of a statement of the patient's emotional object (O) as antecedent ("I lost my job"), and a statement of the patient's *rating* (R) of this object as consequent ("I'm a failure"). R includes the *emotional content* of the inference (for example, John's reference to himself as "a failure"). This rule is typically assumed rather than explicitly stated or thought by the patient. The LBT analysis makes this premise explicit (Cohen, 2005). The second report premise subsumes O under the inference rule. The conclusion, in turn, contains R, as deduced from the two premises (Cohen, 2013). Thus, the explicit form (Cohen, 2016) of this inference is:

- If O then R
- O
- ∴ R

LBT therapists identify the patient's emotional reason-



Elliot D. Cohen, PhD

ing by finding the patient's O and R components and insert them into the explicit form; they then help the patient identify irrational premises (for example, self-damnation in the rule premise).

### **The Ventromedial Prefrontal Cortex and Emotional Reasoning**

Recent fMRI, lesion, and electrophysiological brain studies provide a large body of evidence to show that the ventromedial prefrontal cortex (vmPFC) is linked to value-based decision-making and regulation of negative emotions. Not only does this evidence show that the vmPFC inhibits negative emotions, there is evidence that it also plays a role in *generating* negative emotions (Hiser & Koenigs, 2018). Further, there is evidence that, when subjects engage in reasoning/inferences having emotional content, ventromedial prefrontal cortices (VmpFC) are active. In one study Goel and Dolan (2003) produced fMRI brain scans of 19 subjects while they engaged in a deductive reasoning activity which required them to determine the logical validity of 60 emotionally charged syllogisms and 60 emotionally neutral syllogisms. An example of each type of syllogism is as follows:

#### *Emotionally Charged Syllogism:*

All child molesters are perverse.  
Some child molesters are priests.  
∴ Some priests are perverse.

#### *Neutral Syllogism:*

No poisons are sold at the grocers.  
  
Some mushrooms are sold at the grocers.  
  
∴ Some mushrooms are not poisonous.

Subjects were asked to rate the emotionality of the syllogisms on a scale ranging from +5 to -5, where 0 = neutral. The scale defined high emotionality as making subjects feel “stimulated,” “tense,” and “excited”; and low emotionality as making subjects feel “relaxed,” “calm,” and “dull.” Based on the examples provided, the syllogisms appear to have included mostly, although not entirely, negatively charged terms—“murderous,” “criminals,” “perverse,” “not innocent,” “pimps,” “handicapped,” “not smart,” “rapists,” and “expendable” (Goel & Dolan, 2003, p. 2316). To distinguish between subjects’ emotional responses that were functions of the *inference* activity itself rather than simply responding to the emotional content of the syllogism, Goel and Dolan (2003) provided a baseline condition for both emotional and neutral syllogisms in which the conclusion was clearly irrelevant to its premises so that no reasoning was needed to determine the invalidity of the argument. Examples of such baseline syllogisms are as follows:

#### *Emotionally Charged Baseline Syllogism:*

Some wars are not unjustified.

All wars involve raping of women.

∴ Some Indians are dishonest.

*Neutral Baseline Syllogism:*

Some Canadians are not children.

All Canadians are people.

∴ Some babies are curious.

Goel and Dolan (2003) found that subjects’ fMRIs in the case of emotionally neutral syllogisms, relative to the neutral baseline, were correlated with blood oxygenation changes in the left dorsolateral prefrontal cortex (dlPFC) whereas fMRIs in the case of emotionally charged syllogisms, relative to the emotional baseline, were correlated with changes in bilateral vmPFC activity. The vmPFC responses to the emotionally charged syllogisms were stronger when the content was rated by subjects as more emotionally charged, whereas the dlPFC responses to the neutral syllogisms were stronger when the content was rated as *less* emotionally charged. The researchers concluded that “[The] VMPFC is engaged by the reasoning *process* in the presence of emotional saliency” (Goel & Dolan, p. 2318, italics added). Conversely, the dlPFC is engaged by the reasoning process in the case of emotionally neutral syllogisms. Further fMRI study also suggests that the dlPFC may be engaged in neutral reasoning involving reappraisal or assessment of emotional reasoning (Winecoff, et al, 2013).

In addition, there is evidence that an intact vmPFC is *necessary* for the functional capacity to engage in emotional reasoning. In one controlled study, the reasoning capacity of patients with damage to the vmPFC was impaired *only* in the case of emotional reasoning, but not in the case of reasoning with neutral content (Nicolle & Goel, 2013). Further, there is fMRI evidence showing that during negative emotions such as depression, the vmPFC is active, and inactive when the depression resolves (Koenigs & Grafman, 2009a). Corroboratively, the vmPFC appears to be a natural locality for emotional reasoning to occur because it has bidirectional connections to major limbic system structures including amygdala and hypothalamus, which are active in emotional responses (Siddiqui et al, 2008).

### **Significance of Findings for the Efficacy of Logic-Based Therapy Interventions**

These findings suggest that, insofar as LBT successfully recreates the patient’s dispositional emotional reasoning, it proximately keys into corresponding dispositional vmPFC inferential activity requiring therapeutic manipulation. For example, LBT’s construction of John’s emotional reasoning when he is depressed about losing his job would encode corresponding inferential activity conducted on his vmPFC. More formally, where  $VmPFC_t$  is the inferential activity conducted on a patient’s vmPFC at time  $t$  when the patient experiences a negative emotion, and ER1 is LBT’s construction of the patient’s irrational emotional reasoning at  $t$ , then

(VmPFC1 → ER1) & (ER1 → VmPFC1)

where “→” represents encoding of VmPFC1 to ER1, and conversely. As such manipulation of ER1 to alternative emotional reasoning that avoids the irrational emotional reasoning can also manipulate VmPFC1:

VmPFC1 → ER1

~ ER1 [more rational emotional reasoning]

∴ ~VmPFC1

For example, ~ ER1 might be ER2:

If I lost my job then this can give me an opportunity to finally pursue something else I might like even better.

I lost my job

∴ I now have the opportunity to pursue something else I might like even better.

In LBT, cognitive restructuring involves working cognitively and behaviorally with the patient to replace the irrational syllogism with a more rational one (Cohen, 2017, 2013), for example, replacing ER1 with ER2 so that the disposition for VmPFC1 is replaced with a set of neural connections that resolves the depression.

### Possible Clinical Evidence

Clinical application of the LBT model often involves having patients engage in emotive imagery where patients are asked to imagine that they are in the actual situation that evokes the emotion under investigation (Cohen, 2016). For example, John may be asked to imagine how he experiences depression about the loss of his job. While in this state, based on information that the patient discloses about the O and R elements of the emotional reasoning in question, the therapist attempts a formulation of the patient's emotional reasoning and asks the patient if the formulation is accurate. If the patient indicates that the formulation is not accurate, the therapist works further with the patient to revise and reformulate the patient's emotional reasoning until the patient affirms that the formulation is a match. Almost invariably, this therapist has noted that patients are quite confident about whether a formulation is a match. Based on the empirical data described above, it may be hypothesized that the match is between the engagement of the patient's vmPFC and the proposed formulation of the patient's emotional reasoning. In other words, encoding the inferential activity conducted on the patient's vmPFC would, under the described clinical conditions, yield the given formulation. Further fMRI studies are necessary to confirm this clinical hypothesis.

### Implications for Post-Traumatic Stress Disorder (PTSD)

fMRI studies have provided evidence for the hypothesis that PTSD is due to the inability of the vmPFC to inhibit over-activity in the amygdala. Such studies have confirmed that PTSD patients exhibit vmPFC hypoactivity, and hyperactivity in the amygdala (Koenigs & Grafman, 2009b; Hayes et al, 2012). However, studies of patients with lesions of the vmPFC have also shown that lesions to this area slightly reduce the likelihood of developing PTSD, which is the opposite of what would be expected if PTSD were entirely due to the inability of the VmPFC to regulate amygdala activity (Koenigs & Grafman, 2009b).

As such, it is possible that the correlation of hypoactivity in the vmPFC and hyperactivity in the amygdala, in cases of PTSD, represents a correlation without causation. Along these lines, Koenigs and Grafman (2009b) have proposed a hypothesis about the causal role of the vmPFC in PTSD that is supported by lesion studies. According to the latter researchers, the role of the vmPFC in PTSD may be related to its functional role in self-insight and self-reflection. For example, patients with vmPFC lesions experience diminished levels of cognitive-affective symptoms such as self-damnation and guilt. The general hypothesis appears to be that such patients are more disposed to having their vmPFC hijacked by their amygdala as a result of suffering traumas. However, as stated previously, there is also evidence to show that the vmPFC is also involved in *generating negative emotions* as well as inhibiting them (Hiser & Koenigs, 2018). Thus, it is possible that a non-functional vmPFC no longer plays a role in generating certain negative emotions associated with PTSD such as guilt, shame, and empathy. This, in turn, may explain why at least some patients with lesions of the vmPFC are less likely to develop PTSD.

The involvement of the vmPFC in generating negative emotions associated with PTSD may also explain why the use of cognitive-behavioral interventions can be helpful in addressing PTSD (American Psychological Association, 2017) because such interventions aim at changing the cognitions and behavior that sustain these emotions. Further, the possibility of encoding vmPFC inferential activity into the *emotional reasoning* involved in negative emotions suggests that LBT may be a preferred mode of cognitive intervention for patients with PTSD. For example, consider a veteran who suffers moral injury as a result of a traumatic event suffered during active duty in which the patient has come to feel guilty about the deaths of others. Let's say her emotional reasoning is ER3:

If the others were killed in the explosion, then I deserved to die too.



I was the only one who survived; the others were killed when the device exploded.

∴ I deserved to die too.

Notice that the major premise also entails that the others who died in the explosion also deserved to die, which is absurd insofar as no one deserved to die. In such a case the therapist could help the patient refute the troublesome emotional reasoning and replace it with a more rational syllogism such as ER4:

If I didn't deserve to die in the explosion, then I shouldn't condemn myself for surviving.

I didn't deserve to die in the explosion

∴ I shouldn't condemn myself for surviving.

Where ER4 encodes corresponding vmPFC inference activity, replacing dispositional ER3 with dispositional ER4 could help the patient overcome PTSD symptoms related to the former disposition, for example, that of avoiding contexts associated with the traumatic event. Such replacement would be a function of helping the patient to first identify ER3; identify its self-damning major premise; refute this premise (show that it is irrational); construct antidotal ER4; and assign cognitive-behavioral activities (keeping track of emotional reasoning, shame attacking, behavioral assignments, bibliotherapy, rational-emotive imagery, exposure therapy, etc.) aimed at reinforcing the patient's behavioral and emotional acceptance of ER4 (Cohen, 2013, 2016).

## Discussion

There are two related issues that require investigation. First, whereas LBT formulates the patient's emotional reasoning using conditional syllogisms (modus ponens), the study by Goel & Dolan (2003) used more complex categorical syllogisms. (The latter sort of syllogisms relate classes of things such as "humans," "mortals," and "men" using quantifiers such as "all," "some," and "no" instead of logical connectives such as "if then," "and" and "or.") For instance, in a meta-study Prado, Chadha, and Booth (2011) found that different portions of the brain are more consistently activated by categorical syllogisms than by conditional ones. However, Noveck, Goel and Smith (2004) confirmed that more basic inference forms, particularly modus ponens, which is used by LBT, activate the same brain regions that were studied by Goel and Dolan (2003). Further confirmation about the role of conditional arguments using emotional content is provided by Marling (2015) studying the effect of brain lesions on conditional reasoning in traumatic brain injury patients. In this study, subjects with lesions in their left prefrontal cortex were found to be impaired in emotionally charged conditional reasoning. This further supports a meta-analysis of neuroimaging studies conducted by Goel (2007) according to which conditional arguments

are primarily associated with left-lateralized activation in the parietal and frontal lobes.

Second, LBT formulates the suppressed major premise of syllogisms whereas confirmation is required that this premise is represented in the neural pattern that corresponds to the syllogism on the vmPFC. Since the major premise (If p then q) of a modus ponens inference is necessary as part of the validity of the syllogism it is reasonable to suppose that this premise is somehow contained in the neural circuits that represent a modus ponens inference. Otherwise it is difficult to understand how the brain processes basic inference forms such as modus ponens. Further imaging studies are needed to confirm this assumption.

## Conclusion

The emotional reasoning studies discussed above provide substantial evidence in favor of treating patients with emotional problems by utilizing a modality that identifies and examines patients' emotional reasoning rather than simply looking for patients' beliefs that may be disturbing them. This is because, on the proposed hypothesis, the former approach encodes the actual inferential brain processes, and pinpoints the premises from which an emotively charged conclusion is inferred. It catches the brain *in the act of inferring* such a conclusion (for example, "I'm a failure") from a set of premises ("If I lost my job then I'm a failure" and "I lost my job") via modus ponens. In contrast, traditional REBT does not have a consistent mechanism for encoding inferential brain processes, and may only capture a part of an inference such as the conclusion ("I'm a failure"). Inasmuch as related types of cognitive-behavioral approaches, such as Cognitive-Behavior Therapy (CBT), utilize the ABC theory (Albert Ellis' ABC model, 2018), the same may be said of these approaches.

The evidence assembled here points to the need for further investigation. This may take the form of further imaging studies that comparatively examine vmPFC and concomitant limbic system activities in subjects exposed to LBT and traditional REBT. Suggestions for undertaking further study are respectfully welcome.

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**Elliot D. Cohen, Ph.D.** (Brown University), is Director of the [Logic-Based Therapy Institute](http://www.rebtenetwork.org), and Executive Director of the National Philosophical Counseling Association (NPCA). He is the inventor of Logic-Based Therapy (LBT), which he began to develop in 1985 under the auspices of his mentor, Albert Ellis. He has conducted training workshops on LBT widely, most recently in Taiwan, and regularly conducts a six-week distance training program. His books and articles have been translated into many languages including Chinese, Korean, German, and Italian. Among his most recent books are *Logic-Based Therapy and Everyday Emotions* (Lexington Books, 2016), and *Counseling Ethics for the 21st Century* (Sage, 2018). Dr. Cohen also writes a blog on *Psychology Today* called, "What Would Aristotle Do?" Email: [elliottcohen2@gmail.com](mailto:elliottcohen2@gmail.com)

## Division 56 Listservs

Anyone who belongs to Division 56 is added to **div56announce@lists.apa.org** listserv, for news and announcements. Join any of the following lists by sending an email to [listserv@lists.apa.org](mailto:listserv@lists.apa.org) and typing the following in the body of the note: subscribe name (where name is the part before the @, for example, subscribe div56stu):

**div56@lists.apa.org**

**div56childtrauma@lists.apa.org**

**div56dissociation@lists.apa.org**

**div56ecpn@lists.apa.org**

**div56stu@lists.apa.org**

for discussion among members

for child trauma topics

for post-traumatic dissociative mechanisms development

for early career psychologists networking

for student forum



## APA Division 56 International Student Travel Assistance Stipend to 2018 APA Convention

To encourage international participation, the APA Trauma Psychology Division is providing a travel stipend to attend the 2018 APA Convention for international students who are citizens of developing countries and enrolled in a graduate psychology program in their home country, or enrolled in a graduate psychology program in the U.S., and who will be presenting a trauma related poster, paper, or a participant in a symposium or panel at the 2018 APA Convention in San Francisco, CA.

The travel assistance stipend consists of \$1000 for travel expenses to the 2018 APA Convention. Also included is a one year free membership in the Trauma Psychology Division. This stipend is intended as partial support and matching grants or additional support from other institutions and organizations are also encouraged.



*Elizabeth Carll,  
PhD*



*Vincenzo Teran,  
PsyD*

Please note that international students from developing countries are not required to be a member of any Division or APA to apply for the stipend, as this is an opportunity for them to become familiar with APA, if not already involved.

The recipient of the 2017 International Student Travel Award was Elisa Rachel Altafim, a doctoral student at the University of São Paulo, Brazil. The recipient of the 2018 Travel Award is Zeynep Sagir, a doctoral student at the University of Istanbul, Turkey.

Elizabeth Carll, PhD  
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and  
Vincenzo Teran, PsyD  
([vincenzo.teran@gmail.com](mailto:vincenzo.teran@gmail.com))  
Division 56 International Committee

### Invitation to Division 56 Fellows

Division 56 lists the names of all of our Fellows on our website. You can see the complete list by clicking on the following link: <http://www.apatraumadivision.org/85/awards-honors.html#fellows>. We are hoping to link more of our Fellows' professional websites to highlight the amazing work you are all doing. As you will see, some of our Fellows have already provided links. If you would like to link your website to the Division 56 page, could you please send the link directly to Tyson Bailey at [TDBaileyPsyD@gmail.com](mailto:TDBaileyPsyD@gmail.com).

### Social Media News

*Division 56 is on social media! Please join us to get the latest announcements, news, and events.*

# Trauma before Incarceration:

## Examining the Role of Adverse Childhood Experiences

Kayleigh Watters, MA  
Thema Bryant-Davis, PhD  
Pepperdine University

### Incarceration and Mental Health

According to the World Prison Population List, the United States has the highest prison population with 716 incarcerated per 100,000 (Walmsley, 2013), and these high rates of incarceration occur regardless of the fact that victimization rates do not differ from that of Western Europe (Dijk, Kesteren, & Smith, 2007). More concerning though, is that the prevalence of mental health disorders is higher among the incarcerated population than the outside community (Campbell et al., 2016). Indeed, the rate of posttraumatic stress disorder (PTSD) in this population is between 4-21.4% (Campbell et al., 2016) and of the 105,500 women who were serving a year or more in state or federal jurisdiction, almost half had been physically or sexually assaulted prior to incarceration (Lynch et al., 2012). Higher rates of legal involvement among men who experienced sexual abuse have also been documented (Leach, Stewart, & Smallbone, 2016). Thus, exposure to trauma and resulting symptoms are a serious concern among justice-involved individuals, but unfortunately empirical data related to this population are limited. This paper will explore how adverse childhood experiences and exposure to trauma can affect incarcerated persons before and during their prison sentences, and will be considered in the context of California's overhaul of the use of solitary confinement within the prison system.

### Adverse Childhood Experiences

According to Felitti et al. (1998), who first studied adverse childhood experiences (ACEs), there is a strong relationship between exposure to abuse and household dysfunction during childhood and mental health problems as an adult. Those who were exposed to one type of abuse or household dysfunction were likely to be exposed to even more ACEs (Felitti et al., 1998). The higher rate of mental health problems and its connection

to negative childhood experiences can be explained by the ACEs study. ACEs are defined as childhood abuse (psychological, physical, and sexual abuse) and household dysfunction (substance abuse, mental illness, mother treated violently, and member imprisoned; Felitti et al., 1998). Childhood sexual abuse (CSA) is associated with other types of ACEs, and there is a correlation between experiencing CSA and having other ACEs (Dong et al., 2003). This is important because of the implications for incarcerated persons who have experienced more ACEs than the general population (Reavis et al., 2013).

Thus, trauma symptoms and ACEs are elevated in incarcerated populations but there is a lack of research examining specifically how these things are related to one another. Due to the gap in the literature we have a limited understanding of trauma exposure and the resulting symptoms in this population which impacts our ability to develop effective treatments.



Kayleigh Watters, MA

### Adverse Childhood Experiences and Incarcerated Individuals



Thema Bryant-Davis, PhD

Research has shown that ACEs are seen in individuals who are involved in the justice system. Salter and colleagues (2003) conducted a study of males ( $N = 224$ ) who were referred to a sexual abuse services clinic at a mean age of 11 in London. Results indicated 3.1% had considered to have been convicted of a sexual offense, and 8.5% had engaged in sexually abusive behavior (Salter et al., 2003 as cited in Leach, Stewart, & Smallbone, 2016). Ogloff and colleagues (2012), found that 23.8% of the sexual abuse group had at least one offense compared to the 5.9% of the comparison group (Ogloff et al., 2012). The individuals were more likely to be sexually abused ( $M = 32.6$  vs.  $19.2$ ) and were more likely to be imprisoned (4% vs. 0.05%; Leach, Stewart, & Smallbone, 2016).

For each ACE identified, there appears to be an increased risk of violence in males (35-144%; Reavis et al., 2013). This study showed that there were higher rates of traumatic events in the male offender population than

the normative. The incarcerated population is shown to have an increase in ACEs, specifically, sexual abuse in incarcerated men.

## Student Experience

In 2013, I had the opportunity to assist a professor at San Quentin Prison in California with teaching psychology to incarcerated individuals. During one class, the professor taught Erickson's stages of development, to which the men quickly gravitated because it resonated with them and their experiences within their families of origin. The first stage (trust vs. mistrust) was something that most of the men agreed they never completed, and developed mistrust for others, which led to not successfully complete the other stages. I presented information on PTSD, and the prison system during the following class. The men discussed how there is trauma before prison, and how prisons will continue this cycle. I found this very important to this study in which there is a connection between trauma in childhood and the incarcerated population. Every single one of the men I worked with had experienced some ACE. This was very different from what I saw when I was working at practicum sites.

## Trauma-Focused Therapies

Symptoms of PTSD have implications for the functioning and well-being of the individual. It is important that counselors and therapists identify the symptoms of PTSD and use appropriate interventions. However, due to mental health stigma and the lack of access to treatment this can be difficult for some. Trauma-focused therapies (TFTs) have become the main way to treat PTSD (Lenz, Haktanir, & Callender, 2016). TFTs include; trauma-focused cognitive behavioral therapy (TF-CBT), prolonged exposure (PE), cognitive processing therapy (CPT), and eye-movement desensitization and processing (EMDR; Campbell et al., 2016; Lenz et al., 2016). These therapies focus on working through the traumatic memories, and symptoms of PTSD. Within the prison system there are many challenges that can make receiving appropriate treatment difficult. These challenges include restrictions to incarcerated individuals, surprise lockdowns, transfers, and finding a space within the prison for trauma-focused interventions (Campbell et al., 2016). Even with advancements in research on the benefits of TFTs there is still a limited amount of trauma-focused interventions within the prison system.

## Discussion

According to the Bureau of Justice Statistics, the incarcerated population meets criteria more often than the general population for mental health problems. Although the field has recognized this higher rate of mental health diagnosis in this population, studies on this topic have not been updated. Research on ACEs is very limited in the incarcerated population specifically for men. Data-

bases such as EBSCOhost, Google Scholar, and university libraries were searched extensively for "trauma in incarcerated individuals," "prisoners and trauma," and "adverse childhood experiences." The research studies that were found either used a convenience sample or used mental health prisons, and utilized Felitti's initial sample from the 1980s.

Similar to ACEs, the consequences of trauma exposure within and before going into the correctional setting can have physical and mental health costs. Based on the literature, incarcerated individuals have been exposed to more trauma than the general population, have an increased chance for mental illness, and continue to be re-traumatized within the correctional setting. New research needs to be done to compare trauma before incarceration to a control sample based on the population from this decade. A trauma-informed framework should continue to be implemented into correctional facilities because it is essential to understanding the trauma cycle, and assisting with establishing rapport.

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**Kayleigh Watters** received her master's degree from Pepperdine University in clinical psychology with an emphasis in marriage family therapy. She is now a doctoral student at Palo Alto University's PhD clinical psychology program where she is beginning her training as a trauma focused clinician. Currently, She is working

at a middle school as an MFT intern in Mountain View, CA.

**Thema Bryant-Davis** is a professor of psychology at Pepperdine University's Graduate School of Education and Psychology and director of the Culture and Trauma Research lab.

## Review of *Adaptive Disclosure:* A New Treatment for Military Trauma, Loss, and Moral Injury

Litz, B.T., Libowitz, M.J., & Nash, W.P. (2016). *Adaptive disclosure: A new treatment for military trauma, loss, and moral injury*. New York: The Guilford Press.

**A**daptive Disclosure is written with heart and clarity to provide an alternative treatment approach to widely accepted, manualized, Cognitive Behavioral Therapy (CBT) based treatments for service members and veterans who suffer from posttraumatic syndromes. The treatment approach, Adaptive Disclosure, comprises of eight, 90-minute sessions that aim to "plant healing seeds," rather than a "prescriptive dose of a treatment that cures." *Adaptive Disclosure* is written for a clinician who is interested in learning about the principles and fundamentals of posttraumatic stress treatment, with or without prior experience.

The attempt to create distance and distinction from the traditionally taught, used, and accepted approaches is a theme that is evident throughout this sobering book. The first couple of chapters take on the task of summarizing the current understanding of Posttraumatic Stress Disorder (PTSD); the widely used and accepted treatment approaches and strategies for PTSD; a review of the success rate of the CBT based treatments that are used for the military and veteran population; and essence of Adaptive Disclosure and the reasons this new approach is promising to be more effective than the traditional treatments for PTSD. The first major distinction is made between danger-based experiences that create fear-based post-trauma syndromes (the DSM system's approach to PTSD) and the stress-based syndromes due primarily to the experience of *traumatic loss* and *moral injury*. According to the authors, the peri-event reactions, phenomenology, and unfolding needs and corrective elements are significantly different in these three distinct event categories that cause posttraumatic stress syndromes.



Z. Benek Altayli, PsyD

An important strength of *Adaptive Disclosure* is the importance it places on diversity and relationship factors that have outcome implications. One of the chapters is dedicated to educating the reader on the fundamentals of military ethos, how this "code" is related to the etiology of the aftermath of traumatic loss and moral injury, seen in this population. In addition to finding out about facts and additional resources on military ethos, the reader in this chapter can expect to be prompted to contemplate and develop a deeper understanding of the meaning of experiencing post-trauma syndromes for the service members and veterans that is different than civilians. In a related vein to the discussion of the importance of the military culture, ethos and context, a discussion about

the therapeutic relationship and its importance for the effectiveness of any treatment approach is also explicitly discussed. In fact, the general tendency to pay closer attention to following the instructions in the manuals and somewhat neglecting the significance of the quality of the relationship is hypothesized to be one of the CBT based therapies' limitations.

After taking time to establish a good understanding of the perceived strengths and shortcomings of how we currently understand and treat post-trauma syndrome, the latter chapters of the book take on more of a manual feel. Adaptive Disclosure as a therapeutic strategy is described in three steps: (1) Intake session where information about the presenting problem is gathered, the case is conceptualized and categorized in one of the three stress categories (i.e., fear-based stress, loss related stress and moral injury), and the treatment plan is clarified; (2) the following six sessions provide psychoeducation and in the working phase, incorporate an imaginal exposure exercises to facilitate emotional processing of the war experience, uncover relevant associations, and help the service member or veteran to articulate their raw, uncensored beliefs about the meaning and implications of their experience.

Depending on the categorization of the seminal event that is being addressed, the imaginal experience, the meaning making process and the exposure experiences are different; (3) the last session is used to review the experiences, underscore positive lessons learned, and plan for the long haul in light of what was addressed and achieved in the previous sessions. These chapters are written with details, preparing the reader clinician to incorporate the Adaptive Disclosure model into their current practice, and in their work with service members and veterans who suffer from a posttraumatic condition.

*Adaptive Disclosure* is easy to read; the perspectives, ideas, information and instructions are clearly communicated. It is an excellent amalgamation of what is fundamental and what can be considered as new in the treatment of posttraumatic stress. Finally, *Adaptive Disclosure* makes it easy to see how even those who have the most conservative approach to change in their practice

could benefit from reexamining what they know and what they have been doing thus far through the fresh lens that this book provides.

**Z. Benek Altayli, PsyD** is the director of Wellness Center Mental Health Services (MHS), at University of Colorado, Colorado Springs. She has been in this position since 2008. She has focused interest in psychological trauma assessment, diagnosis and treatment; more specifically she is interested in complex traumatic stress disorders and their treatment. Dr. Altayli has experience and expertise with disaster preparedness and response and is a part of APA's Disaster Resource Network. Additionally, she works with and trains other professionals on behavioral crises and emergencies assessment and intervention. Currently Dr. Altayli holds APA and Division 56 memberships, and is serving in the Colorado Psychological Association's Board of Directors.

## Call for Fellows Applications

We invite and encourage individuals who have “shown evidence of unusual and outstanding contributions or performance in the field of (trauma) psychology” with national or international impact (APA's hallmark criteria) to apply for Fellowship status within Division 56. You must have at least five years of post-doctoral experience, be an APA member for one year, and be a current member of Division 56.

APA members who are not yet Fellows of any APA division must meet APA Fellow criteria, apply for Fellow Status according to APA procedures, and complete the APA forms through their Fellow application portal, all described at <http://www.apa.org/membership/Fellows/index.aspx>. You will find everything you need to know about applying at the above APA web address. All application materials for new APA Fellow status, including letters of recommendation, must be submitted through the portal.

In addition to meeting the APA criteria, applicants must meet Division 56 criteria, listed below.

For Division 56, we expect that the “unusual and outstanding contribution or performance” stated in the APA criteria for Fellow Status be specific to the field of trauma psychology. Two or more of the following may provide evidence of such distinction:

1. Being a pioneer in the recognition and application of trauma psychology
2. Publishing important publications to the field of trauma psychology

3. Producing consistently outstanding instructional or training programs that educate the next generation of trauma psychologists or developing important innovations in teaching or education in the field.
4. Demonstrating consistently outstanding clinical work with the traumatized as recognized by international or national groups through citations, awards, and other methods of recognition.
5. Demonstrating consistently outstanding public service relevant to trauma psychology over many years that might include (a) leadership within Division 56; (b) testimony about trauma psychology before courts and Congressional committees or government commissions; (c) service on review panels (e.g., NIH, NSF); or (d) public education/advocacy.
6. Demonstrating leadership in the area of trauma psychology across science, education, policy, and practice internationally and/or nationally.

In order to meet APA's February deadline, Division 56 requires that all new Fellow application materials (including three letters of recommendation from APA Fellows, at least one of whom must be a Division 56 Fellow) be submitted through the APA portal by **November**

**1.** This timeframe will allow our Fellow committee to review all materials, make a recommendation, and forward completed application materials to APA in time to meet their deadline.

If you are a current Fellow in another APA division, we ask that you write a letter describing the ways your

work meets the above Division 56 Fellow criteria. We also ask for either (1) three letters of recommendation from current APA Fellows, at least one of which must come from a Division 56 Fellow or (2) two letters from Division 56 Fellows) (listed on our web site at <http://www.apatraumadivision.org/honors.php>). Please submit these materials by e-mail to Laurie Pearlman ([lpearlmanphd@comcast.net](mailto:lpearlmanphd@comcast.net)). We accept these applications on a rolling basis throughout the year. They do not go through the APA web-based application process.

We welcome all who are interested and qualified to apply! If you know a Division 56 member whose work meets these criteria, please encourage that person to apply.

## Who's Who: Jack Tsai, PhD

### 1) What is your current occupation?

I'm a licensed clinical psychologist for the Veterans Health Administration and associate professor of psychiatry at Yale University School of Medicine where I also direct the Division of Mental Health Services Research. For APA Division 56, I am excited to have been elected to serve as your Member-at-Large.

### 2) Where were you educated?

I received my B.A. from a small liberal arts college in Claremont, California called Pitzer College which is part of the consortium of Claremont Colleges. I then moved to Indiana for my graduate studies and received my MS and PhD from Purdue University and was located at the Indianapolis campus.

### 3) Why did you choose this field?

There's nothing more intriguing and fascinating than the human mind, both when it is working well and when it is working poorly. I also believe many of society's problems and barriers to human flourishing are psychological in nature. Psychology has great potential to address problems at micro and macro-levels.

### 4) What is most rewarding about this work for you?

I enjoy being involved in three major facets of being a psychologist based at an academic medical center- research, teaching, and clinical work. I find what is challenging is also what is rewarding. I'm drawn to difficult patients, tasks, and topics and have been rewarded by the resilience I have built over the years by taking on challenges.

### 5) What is most frustrating about your work?

There are daily hassles at work that we all have to contend with. For me, administrative processes and obstacles often frustrate me and the advice I would give to others is to be nice to your administrative staff to overcome these obstacles together. When I do get frustrated, I'm reminded of Einstein's quote that "every day I remind myself that my inner and outer life are based on the labors of other [people], living and dead, and that I must exert myself in order to give in the same measure as I have received and am still receiving."

### 6) How do you keep your life in balance (i.e., what are your hobbies)?

I love physical activities and believe one of the most important things you can do to maintain good mental health is to have good physical health. I regularly play basketball and train Brazilian jiu jitsu. I have an aspirational goal of climbing the Seven Summits,

I've done two so far.

### 7) What are your future plans?

Since my research is focused on problems like trauma, homelessness, and incarceration, I hope to develop solid interventions that help people deal with these problems but also to build resilience so they can live as independent, productive members of society. In my clinical work, I plan to continue listening to my clients and to increase my understanding of the human condition. There is so much that we still do not understand about ourselves and those around us.

For Division 56, I plan to continue working to build up the Division and feel invested in its community. I wish to also be involved in APA broadly because I believe it's such an important organization for psychologists and our work needs to be made known to our fellow non-members and the public at-large.



*Jack Tsai, PhD*



# Be Part of the Conversation

Division 56 was founded to keep trauma and its effects at the forefront of the conversation within the American Psychological Association. We are focused on bringing together clinicians, researchers, educators, and policy makers to ensure this goal is met across all domains of practice. Join us and contribute to this conversation by submitting to one of our publications, posting on social media, participating in one of our committees, or running for a leadership position.

## Join Us

You can become a part of the Division of Trauma Psychology today by registering online at:

[www.apa.org/divapp](http://www.apa.org/divapp)

\*APA membership not required

### Join Division 56 Today!


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\*Professional Affiliate Membership is offered to individuals who are not members of APA. Applicants must submit a description of professional training in trauma psychology or a related field, a c.v., and the name of a current member willing to provide a brief statement of endorsement. These materials should be submitted to the Membership Chair at [division56membership@gmail.com](mailto:division56membership@gmail.com)

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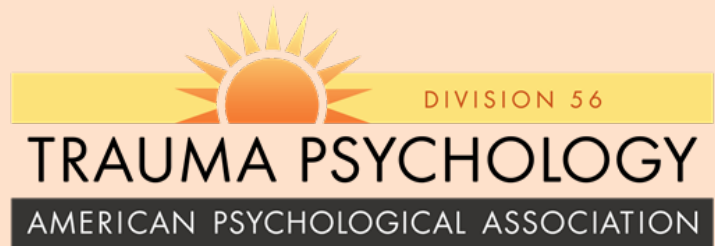
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