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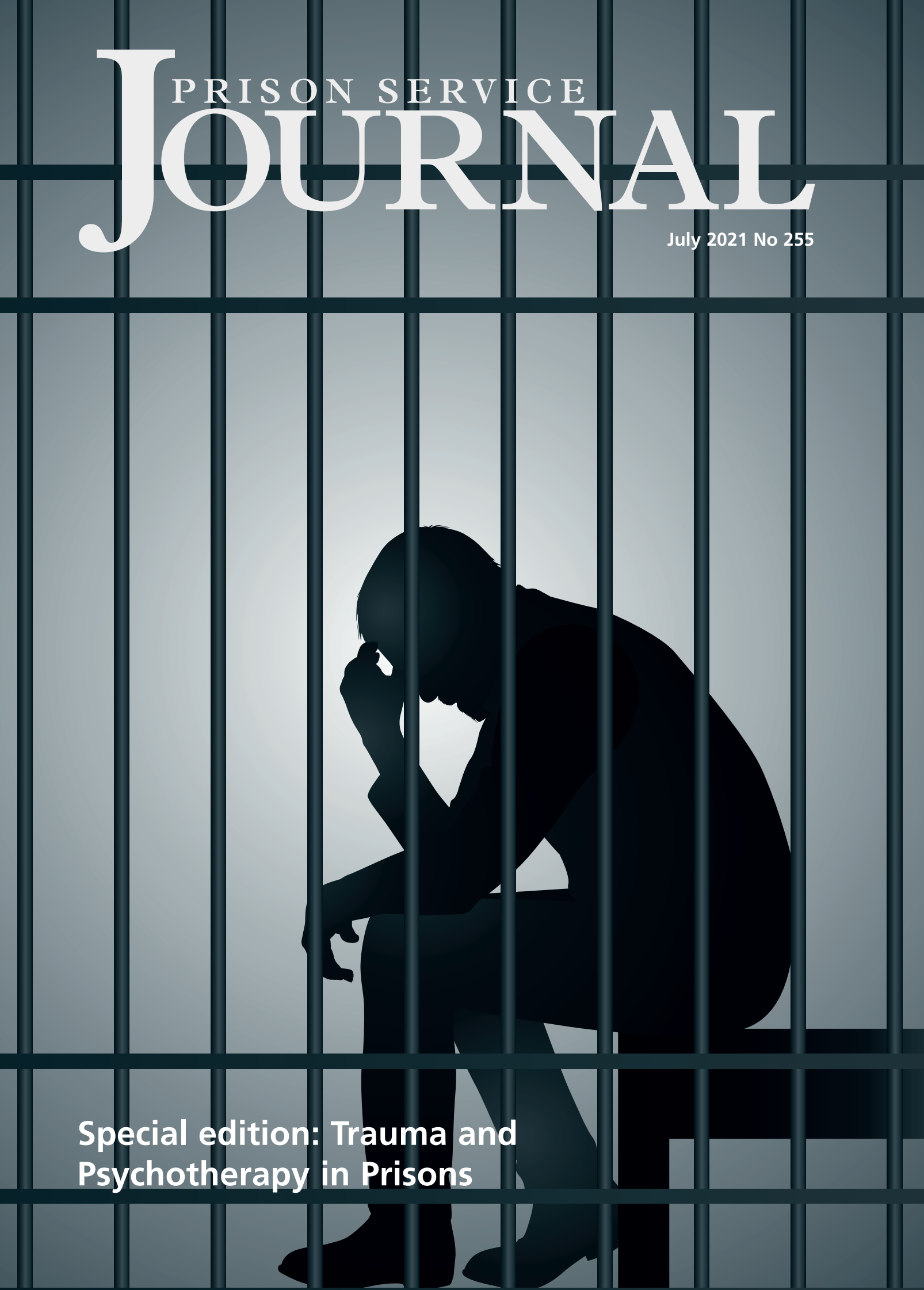

Special edition: Trauma and Psychotherapy in Prisons

Interview with Felicity de Zulueta

Felicity de Zulueta *is Emeritus Consultant Psychiatrist in Psychotherapy at the South London and Maudsley NHS Trust and Honorary Senior Lecturer in Traumatic Studies at Kings College London. She is interviewed by* ***Matt Wotton*** *is Chair of The Bowlby Centre, Co-Director of The London Centre for Applied Psychology and works as a psychotherapist in private practice. He previously worked for more than two decades in the criminal justice system, including as a member of the prison and probation board.*

Felicity de Zuleuta developed and headed both the Department of Psychotherapy at Charing Cross Hospital and the Traumatic Stress Service in the Maudsley Hospital which specialises in the treatment of people suffering from Complex Post Traumatic Stress disorder. She has trained in psychoanalytic psychotherapy, systemic family therapy, and group analysis. She is perhaps best known for her book, From Pain to Violence: the traumatic roots of destructiveness — a seminal text, notable for providing an overview of the traumatic roots of violent behaviour.

This interview took place in late 2020, when Britain, along with much of the rest of the world, was in lockdown as a consequence of the coronavirus pandemic.

MW: I'd like to ask you about your work first, and particularly your book, From Pain to Violence. It is probably a tall order, but could you try to distil the essence of it for readers?

FZ: It's really an argument in 14 chapters giving evidence that shows that we are not born violent. We are born to love, to be loved, and to cooperate. The most recent research using brain-imaging supports this. Our huge brain is the result of our increasing capacity to cooperate with each other We are, by evolution, cooperative.

I didn't know any of this when I started writing my book: my aim was to understand why seemingly nice men were capable of committing horrific acts of violence. I was born at the start of the civil war in Colombia called la 'Violencia' and, though I was too small to remember, I must have seen men covered in blood turning up at my father's laboratory because he was a doctor. I was subsequently brought up in Sarawak, north Borneo, where we lived for over two years in the jungle. We spent a lot of time amongst our neighbours, the Dayaks, who were headhunters before Rajah Brook convinced them to stop. They loved children and made sure that I was safe as I played around in their long houses. After a few years in Switzerland, a real culture shock, our next move was to Uganda, just before the rise of Idi Amin and the horrors that followed. The last country I lived in before coming to the UK to study was Lebanon. You will notice that three of these erupted into civil war after we left!

I suppose, however, that my overriding reason for writing From Pain to Violence was to explore if it was true that we are born with an innate 'death instinct' as my Kleinian supervisors in the Maudsley Hospital were teaching me when discussing my patients in therapy. So it was a journey of discovery for me. My book was informed by the work of John Bowlby, whom I met before his death. Although Bowlby drew on the work of others, he is known as the founder of attachment theory. What his work shows is that we are genetically predisposed to want access and proximity to our attachment figure/s when frightened, in pain or in need. For Bowlby, the biological function of attachment was to ensure the care and protection of the young. It is a behavioural system geared to ensure proximity to our caretaker, during our long period of infantile dependence. Human infants, unlike other mammals, are totally dependent on their caregiver when they are born. The caregiver provides protection of course, but human infants also cannot regulate their own arousal, their emotional reactions, or maintain their physiological homeostasis. They need help with this. That's what the attachment figure provides by responding to the infant's signals via holding, caressing, feeding, smiling etc and giving meaning to the infant's behaviour.

These daily interactions provide the memories that the infant brain synthesises into 'internal working models', to use Bowlby's phrase. The parent doesn't have to be perfect, they just have to be 'good enough' for a secure attachment to develop. This secure attachment protects the child and later adult, from developing PTSD (post traumatic stress disorder) in traumatic situations and gives him or her the resilience to overcome adversity. A securely attached child has a mental representation of their caregiver as responsive, especially in times of trouble. These children are capable of empathy themselves and they confidently expect to get most of their needs met by others, albeit imperfectly.

The problem arises when children develop insecure attachments, because parents are unavailable, neglectful or abusive. Those who end up in the criminal justice system typically have had attachment figures who are neglectful or abusive. Their development is severely impaired, which results in later social problems. They do not trust others. They do not feel good about themselves.

We now know that neglected children feel that no one cares for them and they will tend to blame themselves for that. In so doing, these children retain an element of power and control ('it is my fault') as well as an idealised parental figure to counteract the traumatising parent. In so doing, it enables them to hold onto the hope that, one day they will be 'good' and finally get the love they never had. This is what Fairbairn calls the 'moral defence'.[1] However, these individuals also carry within them the awful feelings of shame; the shame of being made to feel so insignificant.

My colleague in the US., Professor James Gilligan, says the basic cause of violent behaviour is the wish to ward off or eliminate the feeling of shame, impotence or humiliation[2]. This is often an intolerable and overwhelming feeling, which they seek to replace with a feeling of power and pride. A vulnerable sense of self will often, in men, disguise itself behind an appearance of power over others. This behaviour belies their sense of powerlessness. So, when such an individual feels 'disrespected', it can trigger painful memories of humiliation, and violent retaliation follows — it's a desperate attempt to overcome or stop that source of pain. In short, violence is a by-product of psychological trauma and its effects on infants and children.

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MW: Just to play devil's advocate for a moment, the rebuttal to this idea is that violence is less a by-product of trauma, that happened decades ago, and more of a choice — as evidenced by the thousands of people who have a tough start in life, but who do not go on to commit crime or violence. What do you say to those who suggest that we need more focus on resilience and responsibility, rather than treating the perpetrators of crime as victims?

FZ: Looking at the work on adverse childhood experiences (ACEs) is probably the easiest way to try to understand this. The original ACEs study[3] carried out in the USA showed that adverse childhood experiences such as emotional abuse, physical abuse, domestic violence, substance abuse, parental separation and other adverse experiences in the home and in the community, were much more common than previously acknowledged, and that they have a powerful relationship with ill health, both medical and psychological, 50 years later. Of nearly 17,500 adults who took part, more than 30 per cent reported physical abuse, nearly 20 per cent sexual abuse, more than 12 per cent witnessed their mother being beaten, and nearly 5 per cent reported family drug abuse. And remember, this was a survey made up of 70 per cent white and college-educated respondents.

So, it's true that lots of people do have a difficult start, and experience adverse events, but not to the same extent. The study was able to quantify the number of ACEs experienced — it found that the more ACEs, the more likely a person was to develop later problems. Felitti, who pioneered the work on ACEs, described the findings as a surprisingly linear 'dose-response' model: *the higher the ACE score, the worse the outcome in later life.* For example, compared with people with no ACEs, those with four or more ACEs are: two times more likely to binge drink; three times more likely to smoke; four and half times more likely to suffer depression and, relating to your point, seven times more likely to have been involved in violence in the last 12 months. It is important to note that the ACEs represent probabilities, not the actual prediction related to an individual who may have high levels of resilience to counterbalance these effects.

But it's not just the dose-response model that's important or note-worthy. If we think a bit more deeply about ACEs, we see that they are not so much 'events' as ruptured attachments. Emotional and physical abuse fairly obviously points to broken attachments. So, we come back to the importance of the attachment figure/s. That's the key protective factor. A good attachment relationship with a teacher or a relative, such as a grandparent, can also protect children from traumatic homes. Someone with at least one secure

1. Fairburn, W. (1943). Repression and the Return of Bad Objects.
2. Gilligan, J. (1999) Violence: Reflections on Our Deadliest Epidemic. London. Jessica Kingsley.
3. Felitti, V. et al (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study.

attachment can withstand household dysfunctions, such as a parent in prison or misusing drugs, much more so than someone without an attachment figure to help guide them through the pain and confusion of that experience. That is really what determines resilience, or its absence. It's much less to do with personal or moral choice than people think, especially as most acts of violence are spontaneous and take place when the brain is in fight/ flight mode, a state of mind that does not enable one to think things through, as it focuses on the here and now, and whether to attack or escape. Again, it's important to note that the ACEs represent probabilities, not the actual prediction related to specific individuals.

MW: Going beyond your own work in forensic mental health, can you explain a little bit about how adverse childhood experiences (ACEs) impact on physical health outcomes in particular? What I think is so counterintuitive, even to those of us who share the view that adverse early events can lead to anti-social or criminal behaviour, is that they also lead to heart diseases and diabetes!

FZ: Felitti and Anda started with the assumption that ACEs led to chronic ill-health because of behaviours like smoking, heavy drinking, and overeating, which would produce increased rates of lung cancer, liver disease, diabetes, and heart disease. Basically, it's the idea that people who are mentally ill may well also lead less healthy lives. But actually, ACEs had a profound negative effect on adult health even when those behaviours weren't evident. The researchers looked at patients with ACE scores of seven or higher who didn't smoke, didn't drink to excess, and weren't overweight, and found that their risk of ischemic heart disease (the most common cause of death in the United States) was three and half times greater than it was for patients with no ACEs. Somehow, the traumatic experiences of their childhoods were having a negative effect on their health, even though it had nothing to do with poor lifestyle choices.

To understand that better, just think about how your body reacts to severe stress or traumatic events: it produces emotions like fear and terror, as well as physical reactions like increased blood pressure and heart rate, clammy skin, and a dry mouth. But there are other bodily reactions to stress which are less evident: hormones are secreted, neurotransmitters are activated, and inflammatory proteins surge through the bloodstream and into the brain where the damage takes place affecting all the physiological systems. We have, in addition, an added factor to consider which is the epigenetic effect transmitted from a mother suffering from PTSD which makes her child more vulnerable, later in life, to traumatic experiences. Research from New Zealand found that adults in their thirties who had been mistreated as children were nearly twice as likely to have an inflammatory protein in their blood (than those who had not been mistreated). And many studies have shown high sensitivity C-reactive protein in their blood (hs-CRP) to be a leading marker for cardiovascular disease.

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So repeated early adversity can affect the development of the cardiovascular system, the immune system and the metabolic regulatory systems, putting individuals at greater risk for hypertension, heart disease, diabetes and cancer.

It's important to remember here, that we are not talking about the everyday stress which we all experience on a regular basis. We are talking about chronic, toxic traumatic stress which is enduring and where the child feels there is no solution as the needed parent is either unavailable or has become the source of terror.[4]

MW: Nadine Burke Harris, the Surgeon General in California, who is pioneering this work in the US, says, the flight or fight response is very helpful in evolutionary terms if you meet a predator on the savannah, or a bear in the woods, but it's a different story if the bear comes home drunk to your house every evening...

FZ: Yes, exactly right.

MW: The discourse in criminal justice and imprisonment is often characterised by the language of moral choice. How do you view the idea of choice in individuals who have been severely neglected or abused in childhood?

FZ: To make a choice one needs to be able to think. Most acts of violence do not involve the thinking

4. See, for example, the 'still-face' experiment by Tronick, available on YouTube.

brain. As I said before, traumatised individuals have a vulnerable sense of self and are easily made to feel overwhelmed with shame which must then be countered by eliminating the source of pain and humiliation. In the fight/flight mode, the focus is on the act in response to the trigger. Moral issues do not enter into such a mind at that time.

This is why I propose that the most effective treatment for such individuals in prison is to provide them with a therapeutic environment in which their levels of hyper-arousal can be reduced; an environment in which they can begin to learn how to notice and modulate their emotions and to begin to engage in nurturing interactions with others; to start to experience empathy through the experience of attunement with a therapist, or even equine therapy, now used for veterans suffering from PTSD and in a few prisons in the US.

That's why I say that so much of what is done in the name of the criminal justice system is based on a false premise: the idea that we should send people to prison for more punishment is only going to create more damage. We have to break that cycle of violence. To learn to exercise control over his autonomic system, which is over-aroused through traumatisation, the prisoner needs a safe environment in which he can be helped to make choices (perhaps using mindfulness, or yoga techniques etc). This is one of the main aims of trauma-informed care, managing emotions to free the brain to be able to think and make informed choices.

As long as we collude with the populist agendas in labelling the behaviour as bad or 'evil', or insisting on punishment as the way of bringing about change, we only confirm what those individuals often already feel about themselves. And in doing so, we fail to understand, treat or prevent violence in our society.

MW: It reminds me of the quote from the work of your colleague in the US., Dr Andrew Gillian, he says, we're not doing this work to be good Samaritans to 'poor murderers', we're doing this because we need to know what causes violence and we learn that best from violent people.

FZ: Well, quite! Violence as a human phenomenon can be, and needs to be, understood if it's to be prevented.

MW: When I first heard about the ACEs study — a good decade after your book was published — it felt so extraordinary that I thought it really was a break-through idea. Nadine Burke Harris says the same — she assumed she was just late to the party. Yet although ACEs is a well-known concept, it hasn't meaningfully permeated into practice or policy making. If you share that view, why do you think that is?

FZ: The idea that we are so vulnerable is unpalatable particularly to men and this is why the concept of trauma is often dismissed or rejected. Every psychiatric diagnosis, except that of post traumatic stress disorder, is assumed to be biological with a genetic origin, despite the fact that no gene has been found to back this approach. Genes can make us more vulnerable, but there is no known gene for schizophrenia etc.

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Although the science of attachment has been around for several decades since Bowlby published his work and is well supported by research, it's not a paradigm shared by those in positions of power. This is partly because our views on human nature are determined by our own early experiences. Van der Kolk put it well in his book, 'The Body Keeps the Score'. What he meant by that phrase is that trauma leaves its mark. 'Trauma is not just an event that took place sometime in the past, it is also the imprint left by that experience on mind, brain and body. This imprint has ongoing consequences for how the human organism manages to survive the present. Trauma results in a fundamental re-organisation of the way mind and brain manage perceptions. It changes not only how we think and what we think about, but also our very capacity to think'[5].

The shift from a mind that is potentially capable of empathy and love, to a mind that survives by boosting itself at the expense of the other, can sometimes be seen in our leaders. We often see it in our politicians for

5. Bessel A. van der Kolk (2015). The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma. London: Penguin.

example, and it is the result of what can happen to traumatised children — they have to toughen up. Just as they were not met with empathy, so they cannot now meet others with empathy.

Their view of others as is a competitive one, an ideal mental state for a future district officer in the empire or a successful CEO, but disastrous for those who are not given the means to make it up the social ladder. Many of us have been taught, or we have assumed from what we've witnessed growing up, that life is about survival of the fittest. But the political mantra of 'each one for himself' flies in the face of current research: we need loving care to grow up confident and secure and we need to feel that we belong to a community where we feel valued and to which we can contribute. Many of those who are suffering from mental and physical illnesses feel alone and alienated and cope by hurting themselves or others if given the chance.

These are the principles underlying trauma-informed Care when it is used to deal with children and adults who suffer from the effects of adverse childhood experiences. It is based on the idea of providing a safe setting where attuned or empathic care can promote resilience and thereby avoid re-traumatisation. It is cooperative, that is it engages different relevant services to work in a cooperative way, based on attachment principles, in relation to children, their families and their community. This approach is now widespread in the US, but it is also beginning to be infiltrate the UK, particularly in Scotland and in Wales, where it is being tried in prison.

However, there is bound to be negative reaction to this innovative approach to health care because there are also some powerful economic interests involved with prisons and the NHS, both of which are being privatised. Similarly, big pharma has little interest in getting people off drugs, with the result that the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association, does not acknowledge the existence of complex or developmental trauma — that is the combined effect of ACEs over time. Fortunately, the most recent revision of the International Classification of Diseases (ICD 11), published by the World Health Organisation, does recognise this. It's clear that the established system is resisting change but, as the levels of mental illness, PTSD, domestic and social violence rise, due to the increasing inequality resulting from the Covid-19 pandemic, social levels of violence and prison conditions are likely to get worse. I assume that any program that can offer a cost-effective approach to these problems may well be easier to introduce, especially if it has been successful elsewhere.

MW: The most recent Public Accounts Committee report[6] says the government does not know how many prisoners have mental health problems — with estimates between 10-90 per cent. I know you take the view that almost the entire prison population has experienced mental health problems. If that's right, what should we be prioritising: trauma-informed care, more psychotherapy, standardised screening tools? Or do we need to go much further? The head of the National Audit Office said that improving mental health in prison will require a step-change in effort and resource. So, do we need to look to somewhere like Norway as the model for more wholesale change?

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FZ: I think almost everyone in prison is suffering from mental health problems. The research in this country showing a high prevalence of up to 90 per cent is from the 1990s but there is no good reason to suppose that picture has changed since that research was conducted. It's also mirrors more recent international research, which confirms the picture. Out of these prisoners, 27 per cent suffered from child abuse, 46 per cent came from homes with domestic violence, and 62 per cent used drugs, usually used to cope with traumatic symptoms. On top of this, the prison population has doubled since the 1990s, and overcrowding is a serious problem. To make matters worse adults released from custodial sentences of less than 12 months had a proven reoffending rate of 61 per cent, whilst prisons like Bastoy in Norway have the lowest recidivism rate in Europe, at 16 per cent. They pride themselves on treating their clients like responsible human beings and prepare them for a life in the outside world.

6. House of Commons Committee of Public Accounts. Mental health in prisons. Eighth Report of Session 2017–19

In terms of what needs to be done we come back to the idea of using a trauma-informed Care approach. We have to continue to push this agenda, but we need to recognise that change will probably come from the ground up, as is happening in the north of England and in Wales and Scotland — all signs of progress. It seems to me that the further you get from London, the easier it is to do this work. But even in London we have good work going on. The London ACEs Hub has just acquired its website to promote and connect all ACE informed projects in the capital. I encourage anyone interested to go online and join us. Basically, I think you chip away at it. You do what Nadine Burke Harris is doing in the US. You make friends. You make links. You do things one pilot at a time. One prison at a time. One wing at a time, if you have to.

Of course, I would like the system to go further. I come back to my statement that much of what is done in the name of the criminal justice system is based on a false premise. The idea that we send people to prison for more punishment only creates more damage. That's why what they are doing in Norway makes sense. And don't forget, for a long time, Norway's prison system emphasised punishment and security. But challenges similar to those we currently have here — violence, drugs and high recidivism rates — combined to create enough political will to try a different approach to solving these problems. And in 1998, Norway made a sharp shift away from retribution to focus on rehabilitation.

But even if policy makers and politicians aren't quite ready to make that leap, there are other much smaller scale developments they could consider. I am thinking of Video Interactive Guidance (VIG) which is evidence-based, effective and cheap. It's a strengths-based intervention, which highlights and builds on positive moments within relationships, by using video clips of interactions to enhance and attune communication. Participants are supported to view and then build on the 'best moments' in their interaction with others (often their children). Whilst reviewing the clip, both the therapists or guide, and the client, explore together the actions that are making a difference. Through this process of mentalisation[7], participants increase their skills in being able to attune to the 'other' and to create more positive and fulfilling relationships with those who are important to them. The training involves a weekend only and then supervision takes place online, in whatever setting the trainee happens to be. It is the most enjoyable and effective therapy to mend relationships that I know and it can be done online with the client and child at home in these difficult times.

I would also encourage people to look at the Traumatic Attachment Induction Test (TAIT) which can be used therapeutically in a forensic setting. And there's the ACEs Overcomers Programme which teaches survivors of adverse childhood experiences how to understand trauma, so they can better care for themselves while continuing to overcome effects of trauma. And of course there is trauma-informed care which we've been talking about quite a lot. There is emerging research which demonstrates that trauma-informed care can also be useful in increasing responsiveness to evidence-based psychological interventions for offending behaviour. So, there is plenty to be done, if there is a will to do it.

MW: Let's finish up by returning to your work. I know you've just completed presenting your work to two large international conferences (online) but I wonder what's next for you and what more are you hoping to achieve over the next 12 months or so?

FZ: I must write my second book and third book! And then, I can hopefully play with my grandchildren and travel around the world to reconnect with all those whom I love and miss. There is still a lot to do.

7. de Zulueta, F. (2006) Introducing traumatic attachment in adults with a history of child abuse: forensic applications. The British Journal of Forensic Practice Vol. 8. Issue 3. Sept 2006.