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## Contents

Editorial ..... 2

**Inducing traumatic attachment in adults with a  
history of child abuse: forensic applications**

*Felicity de Zulueta* ..... 4

**A concept analysis of 'forensic' nursing**

*Alyson McGregor Kettles and Phil Woods* ..... 16

**Motivating convicted sex offenders into  
treatment: a pilot study**

*Eleni Theodosi and Mary McMurran* ..... 28

**A cognitive behavioural group-based educational  
programme for psychotic symptoms in a low  
secure setting: a pilot evaluation**

*Erica McInnis, William Sellwood and Clair Jones* ..... 36

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# Inducing traumatic attachment in adults with a history of child abuse: forensic applications

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## ABSTRACT

Childhood trauma is very likely to produce ill-health and psychiatric disorder in adulthood. The paper discusses attachment theory and various forms of insecure attachment to the parent/caregiver, particularly disorganised attachment behaviour and the traumatic attachment response. Eliciting the (usually hidden) traumatic attachment in adults can give access to the patient's representational models of their parents, allowing a basis for treatment of disorders. The paper describes and illustrates the use of the TAIT technique for eliciting such models.

## KEYWORDS

childhood trauma; attachment  
Traumatic Attachment  
Induction Test; forensic

## Introduction

The importance of childhood trauma in the genesis of violence and adult ill-health in general can no longer be ignored. The Adverse Childhood Experience (ACE) study carried out in the USA showed that adverse childhood experiences (such as emotional abuse, neglect and family dysfunction) were much more common than previously acknowledged, and that they have a powerful relationship with ill-health 50 years later (Felitti *et al*, 1998).

Of 17,337 adults responding to a questionnaire, 11% reported being emotionally abused as a child, 30.1% reported physical abuse and 19.9% sexual abuse. In addition, 23.5% reported being exposed to family alcohol abuse and 18.8% to mental illness; 12.5% witnessed their mother being battered and 4.9% reported family drug abuse.

The study confirmed earlier research showing a highly significant relationship between adverse childhood experiences and depression, suicide attempts, domestic violence, cigarette smoking, obesity and sexually transmitted diseases. In addition, the more adverse the childhood experiences, the more likely a person was to develop heart disease, cancer, stroke, diabetes, fractures and liver disease.

According to Teplin *et al* (2002), people with childhood histories of trauma make up almost the entire criminal justice population of the USA. In one prospective study on children who had been physically abused and neglected, nearly 50% ended up arrested for an offence other than a traffic offence by the age of 32 (Widom & Maxfield, 1996). Three-quarters of perpetrators of child sexual abuse have themselves been sexually abused in childhood (Romano & De Luca, 1997). A prospective study carried out in New Zealand showed that both male and female victims of child sexual abuse had almost five times the rate of a primary diagnosis of personality disorder as the normal population (Goldman *et al*, 1992; Weiler & Widom, 1996) and were three times as likely to be diagnosed with an anxiety disorder (PTSD or an acute stress reaction); in addition, the

females had twice the rate of major affective disorders (Mullen *et al*, 1994). A community-based longitudinal study carried out by Johnson and colleagues (1999) in the USA showed that children who had been abused and neglected were considerably more likely to have personality disorders and elevated symptom levels during early adulthood.

In the UK, similar findings are to be expected, because the levels of childhood abuse are also very high. Although there are no official figures relating to children's deaths due to child abuse and neglect, the NSPCC estimate is of one or two children a week, compared with Sweden where there are no childhood deaths from physical abuse or neglect, allegedly as a result of the banning of corporal punishment over 20 years ago. Rates of sexual abuse in various countries including the UK range around 14% in females and 13% in males (Finkelhor, 1994). Rates of domestic violence in the UK are also very high, with two women killed by their partners or ex-partners each week.

The challenge ahead involves understanding how child abuse can lead to violence and other psychological and physical abnormalities. The root lies in the effects of violence on the brain, particularly the developing brain of vulnerable children in the first two years of life. Attachment theory and research provide us with an important psychobiological framework for understanding how environmental experience can trigger both gene expression and developmental outcomes.

## Attachment and fear

Human infants are genetically predisposed to want access or proximity to an attachment figure, particularly when they are frightened. We owe it to Bowlby (1969, 1973, 1980) and his followers, Ainsworth (1978), Main (Main & Hesse, 1992), to have made the links between human infantile behaviour when separated from their caregivers and the separation studies carried out by ethologists such as Harlow (1974). The latter showed that the longer and the earlier these monkeys were separated from their mothers, the more antisocial their behaviour in adulthood. The psychobiological

substrate of attachment behaviour in humans involves a great part of the right hemisphere and the supra orbital area of the brain, which is important in the empathic perception of other human beings.

As humans are totally dependent on their caregiver in early life, any threat to their sense of security will translate into activation of the attachment system with the characteristic sequence of behaviours: protest, despair and detachment (Bowlby, 1970).

Human infants cannot regulate their arousal and emotional reactions, gratify their emotional needs or maintain psycho-physiological homeostasis. As a result, a sensitive caregiver will, in addition to providing protection for the infant, allow for the development of psychobiological attunement between infant and caregiver, a process that provides, from birth onwards, a matching of inner states between mother and infant described by Stern as 'affect attunement' (Stern, 1985). The caregiver responds to the infant's signals by holding, caressing, feeding, smiling and giving meaning to the infant's different experiences. These daily interactions provide the memories that the infant brain synthesises into 'internal working models' (Bowlby, 1988 pp129–33). These are 'internal representations' of how the attachment figure is likely to respond to the child's attachment behaviour.

### *The development of the secure attachment*

At the same time, the representation of the infant's sense of self will develop, closely intertwined with this 'internal representation' of the attachment figure(s). If a satisfactory attunement takes place between caregiver and infant, this experience will translate into a sense of security for the child, whose mental representation will be that of a caregiver who is responsive in times of trouble. Such a child will feel confident and capable of empathising with others, thereby forming good attachments. According to Schore, this type of attachment becomes a primary defence against trauma-induced psychopathology in later life (Schore, 1996, 2000).

### *Reflective functioning*

While psychobiological attunement takes place and working models are being developed in the brain, the caregiver of a secure child is giving meaning to the child's behaviour by sharing and predicting his or her behaviour (Fonagy & Target, 2000). This developmental acquisition, defined as 'reflective functioning', enables people to understand each other in terms of both mental states and intentions. It is seen as central to developing a sense of agency and continuity as well as enabling the growing individual to interact successfully with others (Siegel, 2001).

### *The development of insecure attachments*

Insecure attachments develop when infants do not have a mental representation of a responsive caregiver in times of need, such as when they feel fearful or in need. These infants develop different strategies to gain access to their caregiver in order to survive. Three types of insecure attachment behaviour have been recognised using the Strange Situation, a separation test carried out on one-year-old infants (Ainsworth *et al*, 1978).

Group C – 'resistant' or anxious ambivalent type (12 % of the population) – infants have to make their presence known to their inconsistent parent so that they are not ignored. This leads to a clinging, angry behaviour and, according to the long-term prospective Minnesota study, probably to anxiety disorders in the future (Sroufe, 2005 p361).

Group A – avoidant type (20-25% of the population) – infants have learnt to maintain proximity to their rejecting caregiver by acting as if their parent does not matter but their elevated heart rate, when they are separated, betrays their fear. To achieve this state of detachment, these individuals have to deny and denigrate the love and care they need when faced with loss, helplessness or death as occurs in traumatising experiences. They are likely to develop conduct disorders in childhood (Sroufe, 2005 p361). The same study showed that both resistant and avoidant attachments were moderately correlated with depression in later life.

Group D – disorganised type (around 15% of the population) – was discovered later by Main and Hesse (1992).

### **Disorganised attachment behaviour**

Infants with a disorganised attachment display an unpredictable response in relation to their caregiver at the age of one (a mixture of A and C behaviour), and are seen to freeze in trance-like states when they meet their caregiver after a short separation. They behave like sufferers of post-traumatic stress disorder or PTSD, and this is because their caregivers are either frightening or frightened. In the latter case, the parent suffers from PTSD. Such a phenomenon can be observed in women who have been raped and whose children can trigger in them the terrible memories of what they experienced at the hands of their abusers. At such moments they are unable to respond to their child's attachment needs.

The terrifying or terrified behaviour of these caregivers leaves their infants in a state of 'fear without solution' since the 'secure base' represented by the attachment figure has become the source of terror (Main & Hesse, 1992). This process results in the development of what we describe as a traumatic attachment for the child.

### *Attachment and dissociation: the development of the 'traumatic attachment'*

The infant's psychobiological response to a state of 'fear without solution' comprises two separate response patterns – hyperarousal and dissociation (Schore, 2001), a 'fight-flight' response mediated by the sympathetic component of the autonomic nervous system resulting in an increased heart rate, blood pressure, respiration and muscle tone as well as hypervigilance. The infant cries in frantic distress. There is stimulation of the thyroid system and of the hypothalamic pituitary axis (HPA). In these 'kindling states', the high levels of nor-adrenaline and adrenaline lead to the release of glutamate, a major excitatory transmitter in the brain in the limbic system. In such states symbolic processing is not possible, with the result that traumatic experiences are stored in sensory, somatic, behavioural and affective states (Perry *et al*, 1995).

If 'fight or flight' is not possible, a parasympathetic dominant state takes over, and the infant 'freezes' as mammals do in similar circumstances in order to conserve energy or feign

death and thereby foster survival (Nijenhuis *et al*, 1998). In this state, endogenous opiates are released to produce numbing of pain and immobility as well as loss of vocalisation, a phenomenon we also find in humans suffering PTSD when experiencing a flashback under the PET scanner (Rauch *et al*, 1996).

In traumatic states of helplessness, both responses are hyper-activated in the infant, leading to 'an inward flight' or dissociative response. Children, and later adults who have lived in fear of their caregiver, will:

*maintain their attachment to their desperately needed caregiver by resorting to dissociation; in other words, they will develop an idealised attachment to their parent by dissociating off their terrifying memories of being abused. The resulting working models are those of an idealised attachment relation and that of a 'dysregulated self in interaction with a mis-attuning and frightening other' (Schoore, 2001 p240).*

This results in creation of different representations of themselves in relation to their caregiver, or what Bowlby referred to as 'segregated different states' dissociation' (1980 p70). This results in a lack of self-continuity in relation to the other, manifest in people suffering from a borderline personality disorder (Ryle, 1997; Zulueta, 1999) and other dissociative disorders (Ogawa *et al*, 1997). In such conditions, the development of a capacity for reflective functioning is severely impaired (Fonagy & Target, 1997).

They will also hold on to the 'moral defence' whereby they will blame themselves for their suffering and thereby retain power and control as well as hope for better parenting in the future (Fairbairn, 1952). This also results in reinforcing their identification with their abusing parent. When such an individual grows up, he or she will consciously maintain a 'wholly favourable image of a parent' but:

*at a less conscious level he nurses an image in which the parent is represented as neglectful, rejecting or as ill-treating him (Bowlby, 1980 p71).*

Bowlby suggests that the young child does this to protect the vital attachment to the caregiver. However, the price to pay is often severe, he says, because people for whom defensive exclusion plays a prominent part:

*are handicapped in terms of their dealings with other human beings compared to people for whom it plays only a minor part (Bowlby, 1980 p72).*

For example,

*a set of responses a person is making may become disconnected cognitively from the interpersonal situation that is eliciting it, leaving him unaware of why he is responding as he is.*

*He may mistakenly identify some other person (or situation) as the one who (which) is eliciting his responses.*

*He may divert his responses away from someone who is in some degree responsible for arousing them and toward some irrelevant figure, including himself.*

*He may dwell so insistently on the details of his own reactions and sufferings that he has not time to consider what the interpersonal situation responsible for his reactions might really be. (Bowlby, 1980 p65)*

### *The psychobiology of childhood neglect and abuse*

If there is no caregiver to restore the infant's psychobiological equilibrium, the resulting stress-induced unregulated glucocorticoid and neurotransmitter secretions can cause severe damage to the right hemisphere cortical and sub-cortical limbic circuits. This occurs through over-stimulation or under-stimulation of the neuronal circuits at critical periods of brain growth. These changes go hand in hand with other long-term alterations in brain functioning and can result in maladaptive mental health later in life (Sapolsky, 1997). For example, the reduced hippocampal volume reported in female survivors of childhood sexual abuse (Bremner *et al*, 1997) may lead to reduced encoding and retrieval of explicit memory. Similarly, a reduction in cortisol secretion during later stressful episodes can lead to increased

vulnerability to PTSD in later life (Zulueta, 2006 pp198–201; Yehuda, 1997 pp68–9); Henry, 1997).

The resulting loss of ability to regulate intense feelings is the most far-reaching effect of early trauma and neglect (Van der Kolk, 1989). Regulatory failures are manifest in a limited capacity to modulate sympathetic dominant affects like terror, rage and elation, or parasympathetic-dominant affects like shame, disgust, and hopeless despair.

Shame, the emotional reaction of a self that has been totally invalidated, is particularly important in victims of chronic neglect or abuse and is a major trigger for dissociation and violent behaviour. As one of Gilligan's homicidal patients said, 'Better be bad than not be at all' (Gilligan, 1996).

Accompanying this chronic state of high arousal is a reduced ability to use symbols and fantasy to cope with stress because of the functional dissociation between the hemispheres (Henry, 1997). The result is that the trauma victim tends to respond through action rather than thought.

*These victimised people neutralise their hyperarousal by a variety of addictive behaviours, including compulsive re-exposure to situations reminiscent of the trauma* (Van der Kolk, 1989 p401).

Trauma-induced self-destructive behaviour can be found in veterans who enlist as mercenaries, sexually abused children who become prostitutes (Welldon, 1988), physically abused children who recreate their violent abuse with their partners in adulthood and many violent offenders (Gilligan, 1996; Fonagy & Target, 1997; Zulueta, 2005 p39; Zulueta, 2006).

## Eliciting the traumatic attachment (TAIT)

Bowlby stated that in understanding each individual personality development:

*it is as necessary to consider the environment in which each individual develops as well as the genetic potentials with which he is endowed* (1988 p64).

A principle variable in this development is:

*the pathway along which his attachment behaviour comes to be organised and further that the pathway is determined to a high degree by the way his parent-figures treat him...*

*A principal means by which such experiences influence personality development is held to be through their effects on how a person construes the world about him and how he expects persons to whom he might become attached to behave, both of which are derivatives of the representational models of his parents that he has built up during his childhood.*

*Evidence suggests that these models tend to persist relatively unmodified at an unconscious level and to be far more accurate reflections of how his parents really treated him than traditional opinion has supposed* (Bowlby, 1988 p65, emphasis added).

When writing about the therapeutic treatment of patients, Bowlby was equally specific when he wrote:

*A therapist applying attachment theory sees his role as being one of providing the conditions in which the patient can explore his representational models of himself and his attachment figures with a view to reappraising them and restructuring them in the light of the new understanding he acquires and the new experiences he has in the therapeutic relationship* (1988 p138).

The concept of 'working models' or 'internal representations' has until now remained an abstract concept formulated by Bowlby and his followers. They are believed to be operating during the Strange Situation and when adults are interviewed using the Adult Attachment Interview (AAI) developed by Main and Hesse (Hesse, 1999). However, Main points out:

*that these measures can be considered to yield 'representational products' but they are not the same as the 'internal representations' themselves,*

*which are of course inaccessible to direct inspection* (1999 p87).

By eliciting the traumatic attachment, we may be a little closer to observing these 'working models' in action. There is no attachment research to date that describes whether and how such a presumably unconscious 'working model of an infant self in relation to a caregiver' can be directly elicited. However, Johnson, Zulueta and her colleagues at the Maudsley Hospital have found a way of eliciting in some of their adult patients a response that bears many of the hallmarks of a 'working model' or 'internal representation'. This clinically induced experience of 'a self in relation to a frightening caregiver' has been described and recorded in patients who have a history of child abuse, and is referred to as the 'traumatic attachment'. Johnson first published a description of this phenomenon in 1999 (*Box 1*, below).

The 'traumatic attachment' that was elicited with A bears a marked resemblance to the working model that Schore described as that of a 'dysregulated self in interaction with a mis-attuning and frightening other' (Schore, 2001 p240).

Similar responses have been elicited in other patients who have a history of child abuse and neglect (*Boxes 2* and *3* on pages 10 and 11).

#### *On how to elicit the traumatic attachment using the TAIT*

The above examples illustrate how induction of the traumatic attachment using the TAIT involves a semi-structured interview in which various parameters need to be borne in mind.

It should be carried out in a therapeutic context and be preceded by a thoughtful dialogue that focuses on the individual's attachment figures.

The relationship between the therapist and the patient needs to be one of trust in order for the

#### **BOX 1** The case of A, a forensic patient in a high security prison

Dr X had done some therapeutic work with A, a 43-year-old single man who was imprisoned for killing his mate while out stealing in the countryside. On being interviewed by Dr X, A gave a history of being 'battered' by his mother when a child. He had admitted that he was frightened of her and had begun to make links between his fear and his violent behaviour.

The therapist then said 'Say your mother was sitting over there, what would you say to her?' The patient replies 'I'd say 'Mother you can't hit me any more. I am an adult'.

The patient slumps in his chair, looks down and then brings his hand to his face with an accompanying fearful and wary expression - just like the disorganised infants on the return of their caregiver in the Strange Situation Test as described by Solomon and George (1999 p404).

The therapist continues: 'And you believe that'.

'Yes partly' replies A.

Dr X says 'You partly believe it and you partly don't?'

The patient, still looking fearful, says 'Yes. I don't know whether I could say it to her'.

'What would stop you?' asks the doctor.

'Fear' replies the big man in front of him.

'Fear of what? What is she going to do?' asks his therapist.

'Well she might get up and clout me.'

The doctor continues questioning: 'Might she?'

A, still appearing fearful, replies 'Well she might'.

Even after admitting that his mother is now 85 years old and only 5 feet 2 inches tall compared with him, 6 feet 3 inches tall, when the doctor asks him 'And she is going to do you an injury is she?' A replies 'Oh, she is still lively!'. He also admits that he can't disagree with her, let alone hit her. This big man is speaking and behaving like a small boy and, although he does seem aware of the fact that his fear of his old mother is irrational, the reality is that at that moment in time, faced with his imaginary mother, the mother in his head, he can only admit to fear, the fear of a child who is terrified of being battered.

As it turns out, A battered his mate to death when the latter, who had been out stealing with him, insisted that they spend the night in the comfort of his mother's house and 'mouthed' A when he refused. (*Johnson, 1999 pp10-4*)

**BOX 2** The case of B, and why he wants to kill his father

A 33-year-old man was referred to our service by his therapist for an assessment because he had a history of repeatedly self-harming, attempting suicide and trying to kill his father. The latter had been very violent and killed B's mother in front of him when he was six years old. B was subsequently looked after by relatives, who turned out to be violent as well. He was bullied at school and left without any qualifications to join the army at the age of 16. He was medically discharged a year later. B was then given two community orders for attempting to kill his father, who had come out of prison. He was later charged with assault and bodily harm against his partner, mother of his two young daughters. He now lives with another woman and is very fond of his children. Throughout his adulthood, B has been in and out of psychiatric hospital, being treated for post-traumatic stress disorder and depression in relation to witnessing his mother's murder.

During his assessment interview, B was invited to carry out the Traumatic Attachment Induction Test (TAIT). This involved him in briefly imagining his mother and – as an adult – attempting to tell her that he no longer needed her. His reaction was immediate; he could not imagine separating himself from her and doing without her. In trying to say 'I don't need you any more' he felt his chest and abdomen tighten and he couldn't utter a word. When asked to comment about this very brief experience, lasting about a minute, he quickly recognised that this meant that his mother was very much in his mind and that he was still very attached to her. He then admitted that he yearned for her whenever his partner left him to go out, leaving him feeling totally abandoned. At such times, he said, he felt as if he has 'lost everything', just like when he was a boy aged six. It was in such moments that he wanted to join his mother by cutting himself or taking an overdose. B also told us how, when his mother was carried away on a stretcher, she had told him to avenge her. He also admitted to speaking to her through a medium, when his mother had asked him why he had not yet killed his father. He replied that he had tried to do so on two occasions. At this point in the interview, B became very distressed and exclaimed 'but I don't want to kill anyone. I don't understand why I can suddenly become so different and feel I can do it!'

As a result of carrying out the TAIT, B was able to gauge the extent of his attachment to his mother and his accompanying desperate need to kill his father in order finally to access her love and care. This newly acquired insight into his different 'representational models' of himself in relation to his maternal caregiver and its effects on both his current intimate relationship, and also on his recurring wish to kill his father, have enabled this young man finally to make use of the therapy he had been offered and to apply for specialised in-patient therapy.

patient to be able to talk about the feelings of extreme fear and vulnerability that can emerge during the TAIT.

The 'adult self' of the patient is encouraged to be very much in charge before being invited to consider expressing his or her independence in relation to his or her imagined caregiver. What the TAIT is not is a 'role play' experience in which the adult is invited to imagine himself as a child talking to his attachment figure, as is done in certain types of psychotherapy. It is in fact essential to maintain the adult self in the room and in communication with the therapist so that both the patient and the therapist have the opportunity to discover the existence of a traumatic attachment to a caregiver and its accompanying fear response.

Timing is important. The actual TAIT – ie the patient's attempt at facing the imagined caregiver while attempting to break free from the fear he or she elicits – should last only one or two minutes at the most.

As the therapist invites the patient to carry out the test, she instructs him to focus on his body sensations because it is the sudden and unexpected fear response (referred to earlier) with its autonomic manifestations that informs the patient of how terrifying is his attachment relationship to his parent, however childlike or shameful this response may appear to the adult self. Feeling one's stomach churn, one's heart beating or becoming quasi-speechless with terror in relation to what is in fact an imaginary figure, a product of one's mind, can make anyone feel vulnerable and ashamed. For this reason, it may sometimes be more appropriate to ask the patient to carry out the TAIT in their mind using silent speech. The therapist may turn away in order to reduce possible feelings of humiliation. These different approaches become less necessary as the patient's trust in the therapist increases.

After patients have carried out the TAIT, the therapist invites them to tell the therapist what has taken place for them and how disturbing they



**BOX 3** The case of C, once a longstanding patient of a high security hospital

C is a 36-year-old man who was referred to the TSS by the forensic outreach team for assessment and treatment of his traumatic experiences in a high security hospital, where he had been from the age of 18 to 27 following an episode in which he had threatened a taxi driver with an airgun while demanding money. He was diagnosed as suffering from paranoid schizophrenia at the time. He had by then received six convictions for theft, robbery and criminal damage and one for ABH as well as two convictions for possession of an offensive weapon.

At the time of his interview in the TSS he was in a supported hostel in the community and on antipsychotic medication.

His father was very violent towards his wife and his son. When C was two and a half, his parents separated and, after only a few months with his mother, he was put in the care of his father. From then on he had behavioural problems and did badly at school. He went in and out of care, often taken back by his father. His mother died when he was six, a loss that remained unresolved.

When C came for his assessment interview, he presented as a friendly young man with a good sense of humour. We explored what he remembered of his early life and in particular his attachment to his father. Like many children with a history of violent abuse and loss, he would alternate between presenting a rather idealised picture of his father interspersed with fleeting references to being frightened and let down by him. His speech was as a result rather incoherent. This became more evident when interviewed for a second time with a view to carrying out the TAIT in relation to his father who had been his main caregiver.

Bearing in mind that this man came from a culture where it would be disrespectful to tell a father he was not needed any more, C was asked to imagine his father in his head and 'just see what it feels like to say I don't need a dad any more'. C, who had hitherto been extremely talkative, suddenly went quiet and remained so for nearly two minutes, silent and almost immobile, except for the occasional sigh, and his hands would flip in a gesture of despair.

I noted out loud that he looked very sad, and then asked him what had happened, what was it like?

'I don't know really' he replied. 'Certain things as a youngster.'

'Share with me what comes up', I said. 'My past really...'

'What is your body feeling?'

'It's just calm but it's thinking as a youngster... of course... in some sense... I have a scar here and a scar here', he said, showing me his right leg, 'and a scar on my side' he added, pointing to his left side. 'I've never know where they came from. You really know, only something in my mind went blank. I could not think of my childhood. The only thing I could think of is... there was nothing really there. It was as... cold... sometimes I used to sleep rough, I used to run away, and when I came back the police would pick me up, I'd be hit again... He's hurt me several times... If I was to say to anybody... it was my dad sometimes... sometimes I could not believe it was my dad. Some things he hasn't told me and the rest of my family hasn't told me so when I ran away it was... to be looked after, to be free from family shouting at me, giving me the blame. So in one sense what he'd done to me but then there again...'

Following this meeting, C had a brief course of psychotherapy based on focusing on integrating his different views of his father while referring back to the video of the above interview. He has subsequently acquired new skills and developed a more realistic relation to his father, and is now ready to move into his own accommodation.

found the experience in terms of body sensations. The latter can be measured as subjective units of distress, or SUDs, varying from 0 to 10.

The patient's thoughts and associations in relation to the TAIT are the most important aspect of the entire procedure since they usually lead them to develop their own understanding of why they feel and behave as they do, thereby initiating the process of change.

The TAIT can be carried out in relation to either of the individual's parental figures, with differing results. However, it is not recommended to do the TAIT in relation to two caregivers in the same session, as this could be overpowering.

As the TAIT is essentially a tool to help patients understand themselves better, we are now recording these interviews for the patients to keep and analyse. In this way they are given the opportunity

to begin to think about their 'representational models' of themselves in relation to their caregivers and thereby initiate the process of change.

The TAIT can be used as an instrument in the assessment of a patient for therapy, which is what is described in the above clinical examples. It can also be used subsequently as a measure of change during the course of treatment. This was first made apparent in relation to a patient I had treated (*Box 4* below).

## Conclusions

It is in the act of imagined separation from their caregiver during the Traumatic Attachment Induction Test that abused and neglected individuals can discover their 'traumatic attachment' with all that it implies in terms of fear and unrequited longing. Such an attachment can be understood as the internalised product of repeated experiences in which these children have felt both terrified and – paradoxically – desperately

in need of their caregiver, whose protection is felt as essential for their survival.

The TAIT has so far proved to be a powerful tool in revealing some of the psychopathology underpinning dysfunctional and violent behaviour in individuals with a history of childhood abuse. It has the additional merit of making people aware of their traumatic attachments in a very concrete and physical way, through their fear response. This act of self-discovery has the potential to provide individuals with the insight necessary to understand why they behave and feel as they do and to explore the possibility of change in the future. Both the extent of their reaction and their response to the TAIT can give therapists and patients an indication of how difficult that change might be. Not all individuals have the internal and external resources to let go of their 'traumatic attachments'; not all individuals are prepared to give up their childhood longing for love and care – whatever the cost to themselves and to others.

### BOX 4 The case of D, still mourning the loss of her mother

D was one of the first patients to make me realise how relevant the TAIT could be for patients suffering from the long-term effects of child abuse.

She was referred at the age of 25, suffering from severe symptoms of complex PTSD (or borderline personality disorder) and a history of self-harm and serious overdoses as well as a terrifying traumatic attachment to her mother. D was in individual psychotherapy for about four years, focusing on an approach that encouraged mentalisation and the integration of her different self – other states. One of the most concrete changes that she finally achieved was that of being able to look at her therapist's face rather than her feet, such had been the level of terror within her. She ended therapy a very different confident person, who was studying in order to work, and had good friends and an intimate relationship. She also felt she could now 'handle' her mother.

Two years later, D phoned asking for an appointment. Everything was going well in her life and she was in fact about to start her new career, having got a job and passed her exams. What was really distressing her however was that – having achieved all this – she now felt the same destructive and suicidal urges she had had all those years ago before coming into therapy. When asked about her relationship with her mother, she sounded irritated and said that her mother had not congratulated her on her success in her exams. Picking up on this anger, I asked her to carry out the TAIT in her mind. She became angry when she realised how frightened she felt at the thought of doing without her mother; she noted that her stomach was churning and her heart beating fast. She realised that this meant that a part of her was still terrified of her mother and also still desperate to get her love and approval. However, strengthened by her newly found confidence and aspirations, she was determined to 'let go' of this part of herself. Using a ritual outlined in the group therapy described by Ney (1995 pp88–107), she overcame her traumatic attachment and was able to mourn the loss of her childhood longing for maternal love. After three sessions over six weeks, she ended this last phase of therapy, free from any destructive feelings; she even reported a pleasant family occasion in which she had actually enjoyed her mother's company!

Before leaving me, D advised me to develop the use of the TAIT in the assessment of other patients with similar histories of abuse, since the experience had been very valuable for her in achieving a full recovery. Her improvements have been maintained over the last three years and the TAIT is now being used and developed in the treatment of adult victims of child abuse.

Further research is now needed to measure the physical correlates that accompany the TAIT, such as changes in heart rate and skin conductance. Such measures could provide the physiological measurements of the patient's 'fear response'. In addition, the TAIT could be used to assess people who have no known psychopathology or history of child abuse or neglect and with different groups of insecurely attached individuals who have been assessed using Main's AAI (Hesse, 1999).

In the field of forensic mental health, the TAIT could play an important role in the assessment of risk in predicting an individual's potential for violence and in assessing change during and after treatment.

Whether the 'traumatic attachment' that is revealed through the TAIT is in fact the manifestation of a 'working model' or an 'internal representation', or whether it is, as Main put it, another 'representational product', needs to be clarified. What we do observe is an individual reacting physically and emotionally to an imagined internal representation of a caregiver from whom he is attempting to separate, very much as disorganised infants behave in relation to their caregiver in the Strange Situation (Main & Hesse, 1992). This is in itself an important breakthrough in the study of human behaviour, and one that highlights the importance of traumatisation during childhood and its impact on the human attachment system in the genesis and transmission of violence.

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