TTAC

Perinatal and Early Childhood Mental Health Network

Training and Technical Assistance Center

Grief in Early Childhood: Healing the Present, Protecting the Future

Alicia F. Lieberman, PhD
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Who We Are

The New York City Perinatal and Early Childhood Mental Health Training and Technical Assistance Center (TTAC), is funded by the NYC Department of Health and Mental Hygiene (DOHMH).

TTAC is a partnership between the New York Center for Child Development (NYCCD) and the McSilver Institute for Poverty Policy and Research.

- **New York Center for Child Development** has been a major provider of early childhood mental health services in New York with expertise in informing policy and supporting the field of Early Childhood Mental Health through training and direct practice
- **NYU McSilver Institute for Poverty Policy and Research** houses the Community and Managed Care Technical Assistance Centers (CTAC & MCTAC), and the Center for Workforce Excellence (CWE). These TA centers offer clinic, business, and system transformation supports statewide to all behavioral healthcare providers across NYS.

  TTAC is tasked with building capacity and competencies of mental health professionals and early childhood professionals in family serving systems to identify and address the social-emotional needs of young children and their families.

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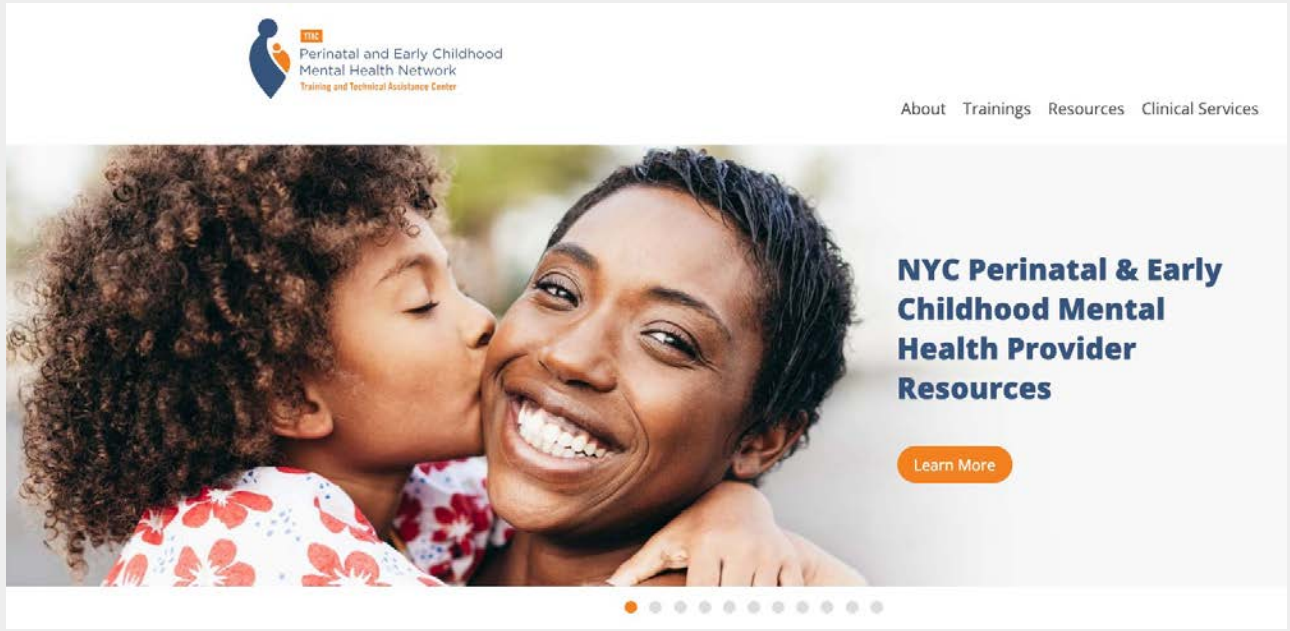

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- Contact the TTAC team by clicking on **Ask TTAC** and filling out our **Contact Us form**
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Child Traumatic Grief in Early Childhood:

Present Impact, Future Sequelae

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Losing a Parent to Death in Early Childhood

"The death of someone we love is the most painful emotional experience faced by human beings, an event that changes our psychological landscape because our personal world can never be the same again without the person that we loved in unique and specific ways. Such a loss acquires cataclysmic dimensions when a child loses a parent because children focus a vast amount of emotional energy on their parents as their main source of love and security" (Lieberman et al., 2002).

"Traumatic bereavement in infants and young children has a special salience. When young children lose a parent, it is common for the death to be due to violence, accident, disaster, or a catastrophic medical event.

And, as young children, they are often with their parents, hearing the cries of distress, witnessing the horror, experiencing extreme helplessness and loss of the very person who normally helps them to handle their own alarm reactions" (Pynoos, 2002).

"There are no peaceful deaths for parents of young children. Whenever we merely say, "his parent died", we leave out the inevitable horror that such a death entails" (Furman, 1974).

Role of Attachment In Early Childhood CTG

- Attachment figures are the sources of protection from danger/feelings of safety
- Loss of the attachment figure is an assault on the child's sense of self
- Attachment figures are not replaceable or interchangeable
- Reunion with the attachment figure is the solution to separation anxiety/fear of loss
- Death makes reunion impossible
- The child experiences anxiety without solution following attachment loss

What is Infant Mental Health?
Developing Competencies, Coping with Challenges

- The capacity to **grow well** and to love well
  -Experience, express and regulate emotions *& recover from dysregulation*
  -Establish trusting relationships *& repair conflict*
  -Explore, learn, *& tolerate frustration*
- These capacities develop within caregiving relationships
  -Secure attachments are the foundation of infant mental health
- All cultures promote infant mental health but each culture has its own ethnography in doing it
  -Diversity of values about the expression of emotion
  -Diversity of values about communal versus individual priorities
  -Diversity of values about sex roles, generational relations, authority

Expectable Developmental Anxieties

- Fear of loss: Separation anxiety "Will you leave me?"
  - *Onset: 6-8 months*
- Fear of losing love "Will you stop loving me if I misbehave?"
  - *Onset: 12 months*
- Fear of body damage "Will I get hurt? Lose part of myself? Die?"
  - *Onset: 12 months*
- Fear of being bad ("Superego condemnation") "Am I bad?"
  - *--Onset: 24 months*

Expectable Developmental Sources of Wellbeing

- Fulfillment of physical needs (food, shelter, homeostasis)
- Safety: Protection from perceived danger
- Interpersonal connection: Intimacy, social stimulation
- Exploration and learning
- Life purpose and meaning: “Raison d’etre”

CTG in Infants, Toddlers and Preschoolers

- Adults underestimate the disabling and enduring impact of loss in young children
  -- "Too cognitively immature to understand or remember"
  -- "Even if they are distressed, they are resilient and recover quickly"
- Phases of separation response in infancy and early childhood
  -- Protest: Urgent crying, frantic search efforts, rejection of substitutes
  -- Despair: Withdrawal, apathy, sporadic crying, muted yearning
  -- Detachment: lack of recognition or attachment response on reunion
- Understanding of finality of death does not emerge until about age 4
- Efforts to bring deceased person back, fantasized reunion
- Immature understanding of causality leads to self-attribution of blame for the death:
  -- "I made it happen"

Factors Affecting the Child's Response: Present Impact and Future Sequelae

- **Child's individual characteristics: Age, developmental level, constitutional/temperamental features**

  -- Large variations within the first 5 years of life

- **Child's quality of relationship to the person who died**

  -- Attachment figure? Beloved sibling?

- **Child's proximity to the event**

  -- Witness?

- **Circumstances of the death**

  -- Sudden? Violent?

- **Environmental Context: Present and past protective/risk factors**

  -- Emotionally available surrogate caregiver(s), family safety and cohesiveness

  -- How other adults respond to the death

  -- Continuity of daily living: Predictable routines

How the Family Responds to the Death: Effects on the Child

- All members of the family are affected by the death
- Grieving involves absorption in one's personal pain
- Each adult is grieving while also needing to care for the child
- Grieving adults may not notice the pain of a small child
- Even when aware of it, they might be too overwhelmed to respond
- Young children are deeply affected by adults' behaviors
- Young children try to do what is expected of them to please adults
- Treatment of young children should include their caregivers

Generalized CTG Responses in Early Childhood

- Persistent fatigue or loss of energy
- Depressed affect or sad facial expression
- Lack of interest in age-appropriate activities
- Self-harming or self-endangering behaviors, recklessness
- Anger, irritability, outbursts of frustration, aggressive behavior
- Guilt, shame, envy and jealousy of other children
- Significant sleep changes
- Significant eating/feeding changes
- Loss of developmental milestones

(DC:0-5)

Specific CTG Responses:
Complicated Grief Disorder of Infancy/Early Childhood

- **Unusual responses to reminders of the loss**

  -- Detachment: Seeming indifference to reminders

  -- Selective "forgetting", such as seeming lack of recognition

  -- Extreme sensitivity to reminders

  -- Strong emotional response to themes of separation/loss

  (e.g., refusal to play peek-a-boo or hide-and-seek)

- **Persistent preoccupation with possible death of self or others**

  -- Repeated questions about dying

  -- Expressing the wish to die

  -- Statements denoting guilt or self-blame

  -- Repeatedly telling strangers about the loss)

(DC:0-5)

Shared Features of CTG and PTSD

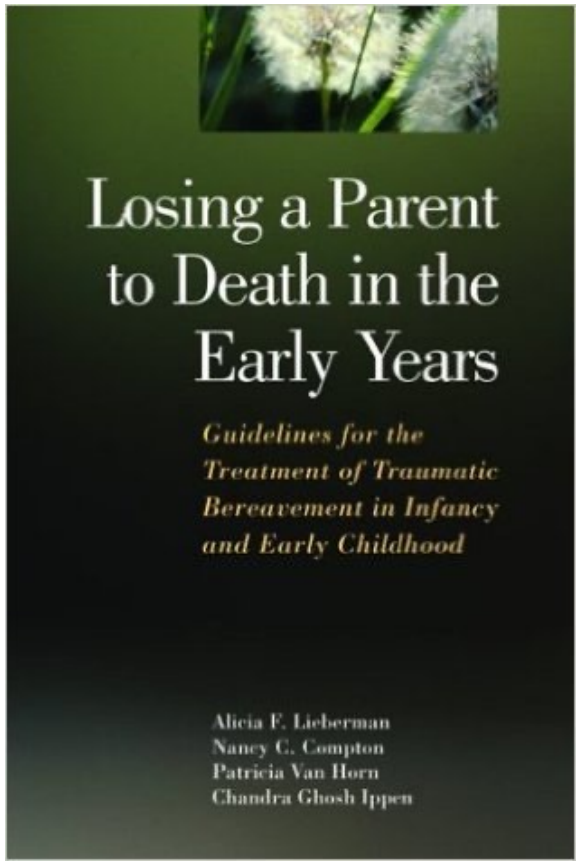
- **Loss of a loved one is a significant stressor/traumatic event for young children**
- **Linking the behaviors to the loss is important for proper diagnosis and treatment**
- **Shared features of PTSD and CTG in Early Childhood**
  - -- Generalized mood and somatic changes
  - -- Play or behavior that enacts or re-enacts themes of death/loss
  - -- Preoccupation with death/loss
  - -- Repeated nightmares, regardless of content
  - -- Significant distress or withdrawal in response to reminders
  - -- Marked physiological reactions at reminders of the death
  - -- Dissociative episodes in response to reminders
  - -- Attention disturbances: Hypervigilance, difficulty concentrating

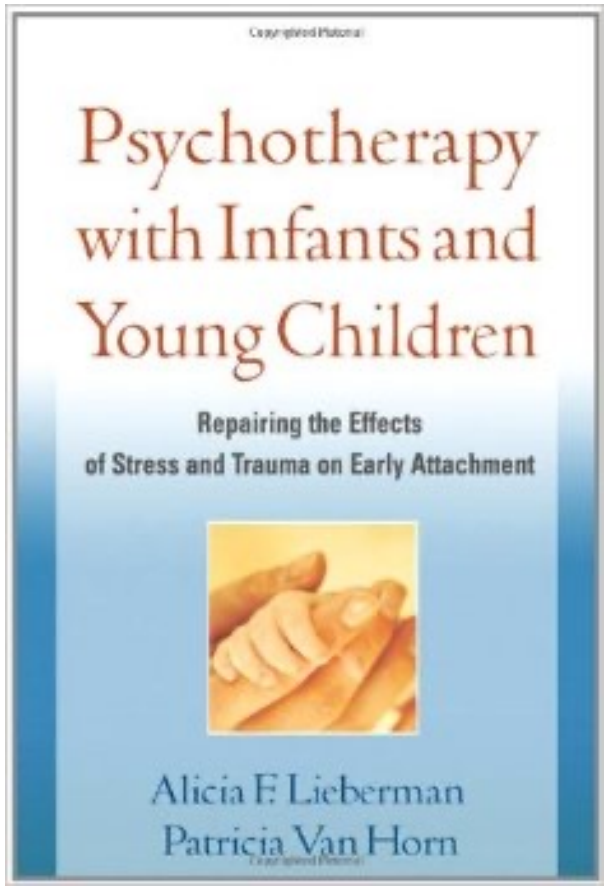
Treating Early Childhood CTG: Child-Parent Psychotherapy (CPP)

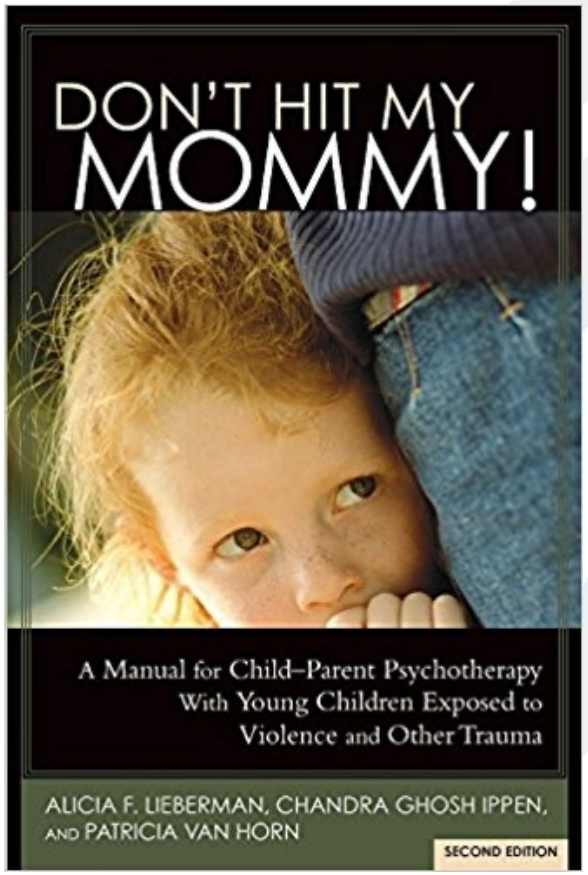
- Relationship-based treatment: Joint child-parent(s) sessions
  - Children aged birth-5 years; Perinatal adaptation (P-CPP)
  - The child was exposed to a traumatic event
  - Trauma addressed through developmental and cultural lenses
  - Dual attention to impact of immediate trauma and to parents' present trauma and unresolved childhood experiences

(Lieberman & Van Horn, 2005; 2008)

CPP Manuals and Books







Child-Parent Psychotherapy Goals: Repairing Trauma, Promoting Healthy Development

- Safety first
- Give words to painful realities
- Validate and modulate affect
- Repair conflict
- Differentiate between reliving and remembering
- Foster safe and pleasurable intimacy

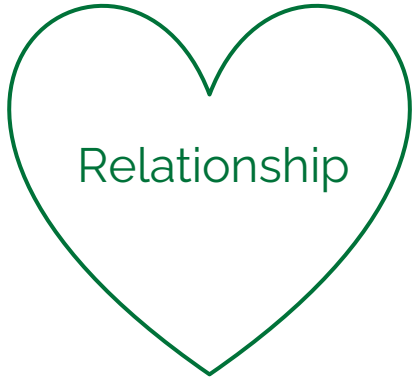
CPP Theoretical Framework

- **Developmentally Informed**
- Attachment focus
- Trauma-based
- Psychoanalytic theory: Ghosts and Angels in the Nursery
- Social Learning processes
- Cognitive–Behavioral strategies
- **Culturally attuned**

(Lieberman & Van Horn, 2005)

CPP Foundational Phase
Core Domains

Child
Trauma History
Trauma Symptoms
Other Symptoms
Developmental Functioning
Strengths



Caregiver
Trauma History
Trauma Symptoms
Other Symptoms
Strengths
Parenting/Functioning

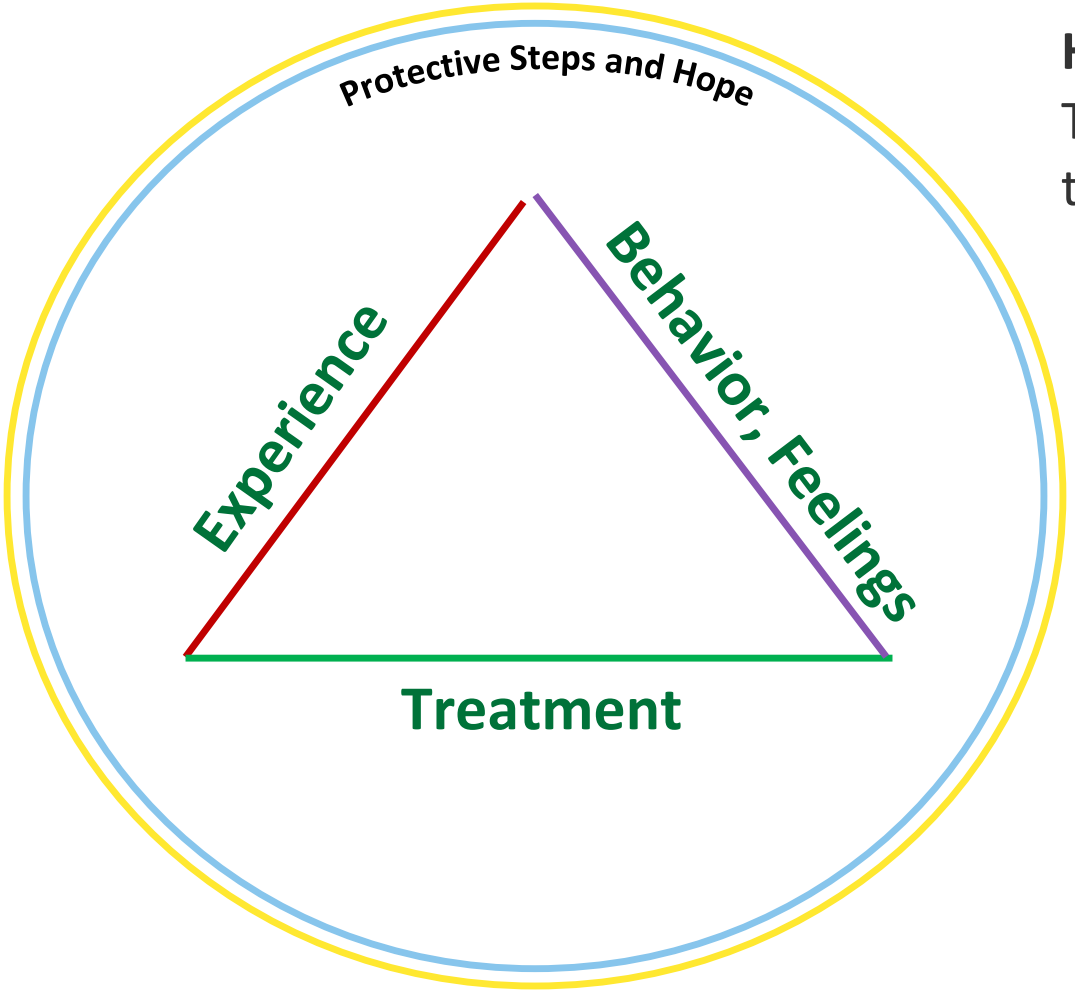
Range of tools to assess these domains

The Feedback Session:
Co-Creating A Treatment Plan with the Child's Caregiver

- Ask before we tell: What was the caregiver's experience of the assessment? Have we attended enough to the caregiver's own grief?
- Build on strengths: Did the caregiver learn something new?
- Describe "Clinical Formulation Triangle" for Caregiver and Child
  - –Link connections among between events and responses/symptoms
  - –Explain how treatment will help
- Assess caregiver responsiveness to the formulation triangle
- Plan together what to tell the child about the treatment

CPP Clinical Formulation Triangle: Making Meaning of Childhood Experiences

Protective Steps:
Highlight constructive strategoes



Hope:
Things can change for the better

Experience:
--You saw…
--You heard..

Behavior, Feelings:
--And now you…

Treatment:
This is a place where…

Lieberman & Ghosh Ippen, 2014

The Feedback Session:
Engaging The Caregiver as Partner

- Does the caregiver buy into the proposed clinical formulation?
- What is acceptable to the caregiver, what is not?
- Among multiple stressors, choose the most relevant to the presenting problems and highlight protective actions
- Explain the role of play as vehicle: “Freedom of Play”
- Create a common ground for what topics can be addressed
- Anticipate and strategize about possible dilemmas

Introducing CPP to the Child

- Set out toys that invite the child to engage in meaningful play
  - Toys that evoke the traumatic event and symbolize protection
  - Toys for pleasure and emotion regulation
- Explain treatment as you and the caregiver agreed during the feedback session
- "Watch, wait, and wonder"
- Work with trauma material but don't force it

CPP Therapeutic Strategies and Tools

" Psychotherapy is a form of play" (Winnicott, 1971)

- Play provides a safe venue to express emotions and communicate wishes and fears
- Body-based interventions: Yoga, breathing, massage, safe touch, physical contact
- Reading, drawing, puppets
- Music
- Putting feelings into words

Who Knows What Happened?
Facilitating A Trauma Narrative

- Parent as informer, observer, re-enacter
  - Parental role in the traumatic event
  - Parental tolerance of child's enactment
  - Parental capacity to help the child

- Child as informer, observer, re-enacter
  - Developmental stage: language and play
  - "Acting out is a form of remembering"

- There are things we will never know and should not presume to know

What Does Speaking the Unspeakable Mean?

- Create a safe space to name and explore responses to painful events that are **consciously remembered** and **acknowledged as real** by the child, caregiver, others
- Speaking about trauma is not traumatizing if done with right timing and deep care
- Shame, self-blame, and the wish for revenge are universal trauma responses
- "Guided free association": Explore possible causal links between the painful event and presenting symptoms to integrate emotional polarities
- Balance attunement to parents' and child's rhythms with awareness of threats to safety

Speaking the Unspeakable to Undo Harmful Beliefs

Recurrent treatment themes:

- What and how to tell the child about the death
- Explaining death to a child who is still too young to conceptualize death
- Giving meaning to the death: Offering answers to “why”?
- Alleviating children’s fears
- Addressing intrusive memories and traumatic reminders
- Consolidating positive and negative memories about the lost parent
- Maintaining the child’s connection with the memory of the parent
- Keeping concrete reminders, observing anniversaries
- Modeling safe separations

Facilitating A Protective Narrative

- Benevolent experiences also last a lifetime: “Angels in the Nursery”
- Re-creating relationships helps to recreate the self
- Life as “chiaroscuro”:
  Normative interplay of light and darkness, positive and negative
- Therapist as agent of hope and repair

Weaving Together Trauma Narratives and Protective Narratives

- Premise: Having reality validated is healing

- Telling what happened takes many forms
  - Somatic re-experiencing
  - Behavioral re-enactment
  - Symbolic behavior/Symbolic play
  - Verbalization

- Observer/Listener's tolerance of unbound feeling helps towards eventual modulation

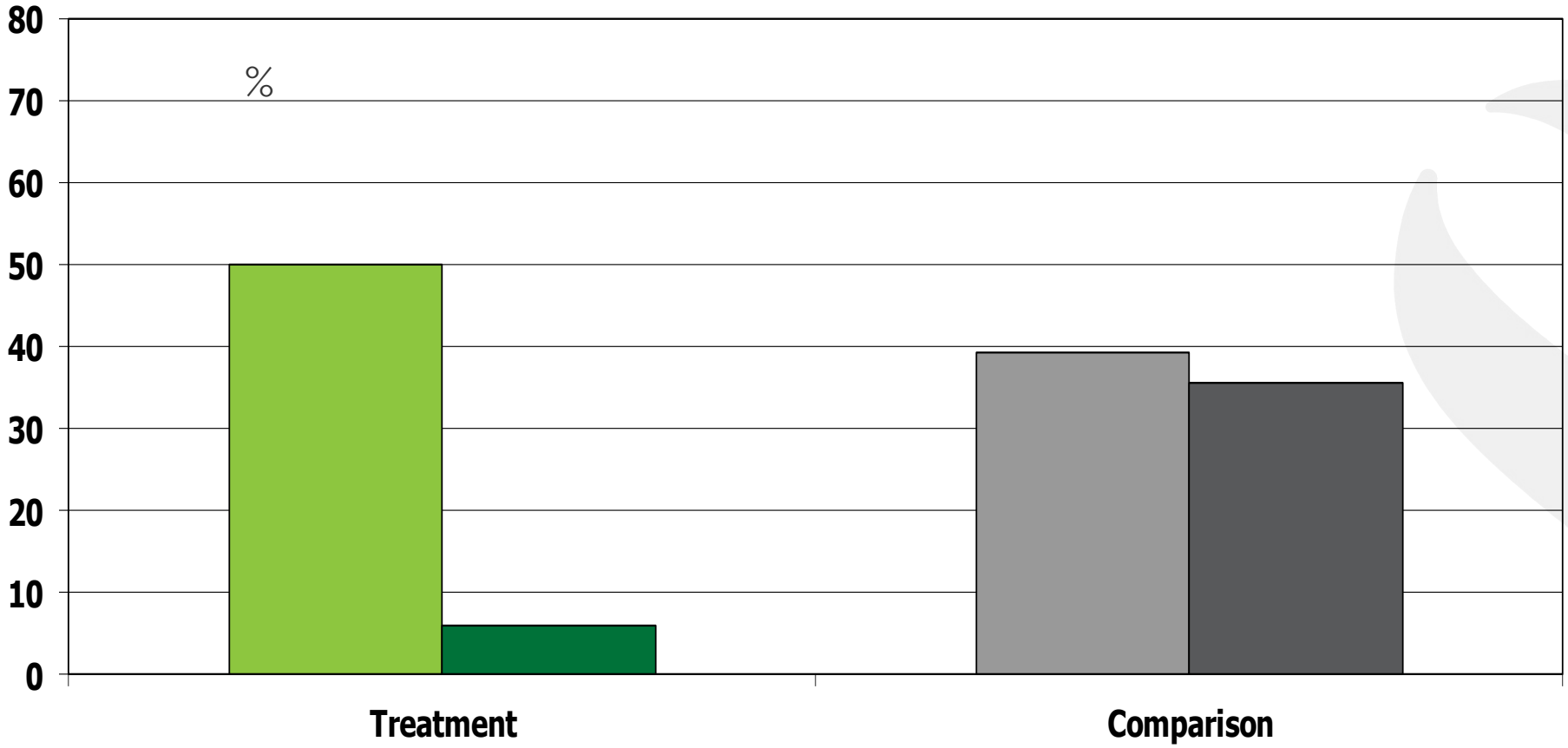
CPP Termination Phase

Optimal criteria for termination:

-- Attachment to new primary caregiver
-- Child re-engagement with age-appropriate activities
-- Range of affect that includes playfulness and joy
-- Integration of the deceased parent's memory
-- Consolidated acceptance of the finality of death
-- Manageable symptoms that do not interfere with child's relationships, developmental trajectory, or family functioning

It Works!

CPP Reduces Child PTSD Diagnosis, Biomarkers of Stress, Behavioral Problems, and Maternal Psychiatric Symptoms



Children Diagnosed with PTSD Before and After Treatment

(Lieberman, Van Horn & Ghosh Ippen, 2005)

Empirical Support for CPP

- Five randomized studies with 520 children and mothers
- Child Ages: 1-5 Variety of SES, Multicultural samples, 1-9 year follow up
- Maltreatment, domestic violence, quality of attachment, maternal depression
- Consistent results of differential CPP effectiveness

Measures: Quality of attachment, cognitive functioning, cognitive representations of self and mother, maternal and child diagnoses, cortisol regulation, cellular aging, quality of marital relationship

(Lieberman et al., 1991; Cicchetti et al., 1999, 2000; Toth et al., 2002; Toth et al., 2006; Lieberman et al., 2005, 2006; Sullivan et al., 2024)

Remembering and Creating Positive Memories

- Benevolent experiences last a lifetime
- Re-creating relationships helps to recreate the self
- Life is a "chiaroscuro":
  There is a constant interplay between light and darkness in nature and in life
- The therapist is a partner in hope and repair

Future Sequelae:
Post-Trauma Growth Happens

- Developmental Psychopathology frame: Interplay of risk and protective factors
- Prediction is probabilistic at best and applies to groups rather than individuals
- The world is dangerous; trauma exposure is an ever-present evolutionary risk
- Suffering can stimulate a search for meaning and lead to emotional growth
- Some of the greatest spiritual, artistic, and scientific achievements result from this search
- Safe relationships are the foundation of mental health across the lifespan

Therapist Self-Care:
Managing Vicarious Grief

- Witnessing young children's pain is heartbreaking and exhausting
- We need to use all our coping resources in caring for ourselves
- "Compassion that does not include oneself is not complete"