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## *Foreword*

This publication represents a watershed in our understanding and approach to traumatic bereavement in infancy and early childhood. It is hard to imagine another group as qualified to have produced this important volume. I am privileged to write this Foreword. It is a special added honor to do so as Co-Director of the UCLA/Duke University National Center for Child Traumatic Stress. Dr. Lieberman directs the Early Childhood Trauma Treatment Network, one of the Intervention Development and Evaluation Centers of the [National Child Traumatic Stress Network](#). After the horrific events of 9/11, this newly established National Network initiated a Traumatic Bereavement Task Force under the outstanding leadership of Judy Cohen, M.D. Although among Task Force members, assessment tools and intervention protocols were available for school-age children and adolescents, there was a critical need to develop specific guidelines for infants and very young children. We called on Dr. Lieberman and her colleagues to help us in meeting this national need. Their dedication to this call has produced the most comprehensive and detailed set of guidelines to date. The guidelines have benefited from the review of Task Force members, as well as members of the UCLA Trauma Psychiatry Program, for example, Lisa Aronson, Ph.D. The work of the Traumatic Bereavement Task Force has been an outstanding example of the added value the Network brings to our national efforts to care for traumatized children and their families.

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 would normally help them to handle their own alarm reactions. Some of the most heartrending young children's literature begins with the violent death of a parent witnessed by their young offspring, as occurs with *Bambi* and *Babar*. These stories typically move past the violent loss and focus on the trials and tribulations of the young survivor's post-loss adaptation. Cahill and colleagues (1994) have provided preliminary biological evidence of how injurious threat to a parent or child elicits extreme emotional arousal and induces emotionally influenced memories, a mechanism that probably serves as a significant underpinning for the longevity of these enduring classics of young children's literature.

The theoretical and empirical literature on traumatic bereavement suggests five core components. These include contending with: (a) the physical reality of the death; (b) the traumatic circumstances; (c) grief reactions, including reactions to loss reminders; (d) efforts at proximal developmental adaptation to the loss; and, (e) the potential distal impact on developmental progression. What is of great reward is to see how each of these has been so well explored and explicated for very young children and their families.

Apprenticeship and mentorship have always been the primary means by which clinical knowledge and wisdom have been transmitted from generation to generation of mental health professionals. We are now living through a period in which there is increasing attention to the importance of operationalizing principles of assessment and intervention. The dual goals are to push forward the development of evidence-based care and expand the transfer of clinical knowledge more broadly. However, as many of us are aware, the resultant products can be squeezed dry of the clinical richness that has always been at the heart of professional mentorship. In contrast, in reading these guidelines, one is aware of the profound clinical sensitivity exercised by Dr. Lieberman and her colleagues in selecting just the right clinical examples to make the principles come alive with all their developmental nuances.

I know first hand how hard it has been to produce these guidelines. The authors have had to work through the inherent human response by all of us to

the enormous consequence of the loss of a parent for an infant or toddler. In our minds, we move quickly to the side of anticipating the seemingly overwhelming developmental reverberations, along with the immaturity to grieve or mourn the loss. We want to reach out clinically to help the child and family contend with the loss. Certainly, as provided by these guidelines, we do have a much greater appreciation of the complexity of even very young children's reactions to such a loss, and a greater repertoire of carefully considered interventions to increase the child's and family's resilience. Yet, in doing so, we have a strong tendency to look away from or to quickly move past the traumatic features of the death and the child's often direct experience of it and overlook how they contribute to a special set of psychological and developmental reverberations. In these guidelines, the authors have assiduously maintained a balanced attention to the interplay of both of these critical aspects of early childhood traumatic bereavement. The reader has to be prepared to see the world of violent, accidental, disaster-related, or medically catastrophic deaths through the experience of infants and toddlers.

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Cahill, L., Prins, B., Weber, M., & McGaugh, J. L., (1994) Beta-adrenergic activation and memory for emotional events. *Nature*, 371:702-704.



## *Acknowledgments*

This book represents a compilation of our experience in providing assessment and treatment to babies, toddlers, and preschoolers who lost a parent to death, and in supporting their families as they struggled to support the child through this life-changing crisis. The grieving children and their caregivers allowed us into their lives at a time of unspeakable pain, when the first response is often to shut off outsiders in an effort to protect oneself. Very young, often preverbal children were eloquent in telling us through their actions, play, and sometimes halting but always searing words that losing a loved one is an emotional catastrophe regardless of one's age. They also taught us that the images of the parent's death, when they witnessed it, were engraved in their minds and affected every aspect of their lives. Their courage in striving to understand, adapt, and continue to grow made us feel that we could do no less as witnesses to their suffering. We thank them and their families for being our guides in this endeavor. We also thank the clinicians of the Child Trauma Research Project for their devotion to the children and families they serve.

We are grateful to the National Child Traumatic Stress Initiative (NCTSI) for the opportunity to write these guidelines. This groundbreaking Substance Abuse, and Mental Health Services Administration (SAMHSA) initiative brings together practitioners and scientists from across the country for the purpose of enhancing the quality and expanding the quantity of services available to traumatized children and their families at a time of great national need. Judy Cohen invited us to write the guidelines and gave us insightful feedback and unstinting support at every stage of the writing. Robert Pynoos was characteristically generous in sharing his unmatched expertise on child traumatic stress and opening up resources that deepened our thinking. We are indebted to the SAMHSA leader-

ship for NCTSI, Robert DeMartino and Malcolm Gordon, for their vision and skill in shepherding the evolution of this initiative from an aggregate of individual programs to a cohesive national organization that translates scientific knowledge into practice to benefit traumatized children and their families. Lisa Aronson provided thoughtful consultation as we endeavored to integrate a loss lens and a trauma lens in understanding the plight of children who witnessed their parent's violent death. Joy Osofsky made available her exceptional knowledge as well as her outstanding editorial skills.

Bill Harris opened new vistas for our work through his advocacy of public policies that are responsive to children's needs. He taught us that science is necessary but not sufficient to implement what we know about the key ingredients for healthy development. Through our work with families in stress, we are frequent witnesses to the nefarious effects of "ghosts in the nursery" — Selma Fraiberg's indelible metaphor for the intergenerational transmission from parents to children of damaging relationship patterns when protective resources are not available. Bill's accomplishments serve as a powerful counterbalance by illustrating the beneficent transmission of life-affirming intergenerational patterns — from his father, Irving Harris, to whom this book is dedicated, to his son and partner, David Harris, who continues the family tradition of setting the standard for effective leadership on behalf of children. Bill Harris encouraged us to search for "angels in the nursery" as inner sources of strength and hope for families in despair. It is only fitting that we apply that image to its author as well.

It gives us pleasure and pride that this book is published by ZERO TO THREE: National Center for Infants, Toddlers, and Families, the prime national organization for children in the first 3 years of life. We thank Emily Fenichel for many years of rewarding collaboration that carry the imprint of her creativity, knowledge, and wit. Her talent in building connections that advance the welfare of children made possible the publication of this book as a cooperative enterprise between SAMHSA and ZERO TO THREE. We thank her for that and for much more.

San Francisco, July 2003

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*Although we know that after such a loss the acute state of mourning will subside, we also know we shall remain inconsolable and will never find a substitute. No matter what may fill the gap, even if it be filled completely, it nevertheless remains something else. And actually this is how it should be. It is the only way of perpetuating that love which we do not want to relinquish.*

*Sigmund Freud*

Sigmund Freud in a letter to Ludwig Binswanger, who had lost a son. Quoted in J. Bowlby (1980) p. 23.

## *Introduction*

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. Younger children in particular are affected because they are almost completely dependent on their parents for their sense of security.

**T**he death of a young child's parent is almost always premature because it is caused by accidents, violence, suicide, or an untimely disease rather than by conditions associated with aging. As Erna Furman (1974) stated, "There are no peaceful deaths for parents of young children. Whenever we merely say 'his parent died,' we leave out the inevitable horror and tragedy that such a death entails" (p. 102). Nobody is truly prepared for such a death, least of all the child, who finds himself suddenly bereft of the person who organized his sense of physical and mental well-being. The parent's death is most disorganizing when the child is too young to understand the meaning of death and when the parent performed the daily caregiving routines that provided the child with the continuity and predictability that are the foundations for early feelings of safety and well-being. In these circumstances, the child suffers a failure of the developmentally appropriate expectation that the parent will be reliably available as a caregiver and a protector. The violation of this expectation causes injury to the integrity and continuity of the child's sense of self (Bowlby, 1980; Pynoos, Steinberg, & Piacentini, 1999).

How a parent's death occurs influences the effect on the child. Factors such as whether the death was sudden or the culmination of a long illness, the extent to which the child was exposed to different facets of the dying process, and the quality of emotional support received by the child at different stages interact with the child's own constitutional, temperamental, and developmental characteristics in shaping the child's response. In extreme cases, the child who witnesses a violent death is exposed to overwhelming stimuli such as scenes of fighting and distress, body damage, blood, agitated movements, screaming and other loud sounds, and specific smells such as those of gunfire and blood. The parent, who in normal circumstances would help to regulate the child's responses, cannot be available because of the state of complete dysregulation preceding the death. In addition, the parent's cries of distress evoke enormous empathic arousal in the child, eliciting a wish to help that cannot be fulfilled through effective action and may generate feelings of helplessness and self-blame. In these circumstances, the parent's protection fails when the child most needs it, and the child's fear and helplessness are intensified by the subsequent exposure to the immobile and unresponsive body of the dead parent. The child also fears for his own safety, compounding the witnessing experience with an additional layer of terror mixed with guilt for thinking of himself instead of focusing only on the parent's needs.

Following a sudden or violent death, other stressful and traumatizing events may occur, including the sight of the injured or maimed body, the arrival of the police and medical personnel, efforts to assist the injured, the grief reactions of other witnesses, and the child's separation from the parent's body. These secondary traumas are encoded as intrusive memories that interfere with the child's ability to mourn because the child cannot remember the parent without also remembering and becoming intensely distressed by the specific manner of the death (Pynoos et al., 1999). In these cases, bereavement and acute anxiety become inextricably intertwined because the child is simultaneously suffering from the loss of the parent and from unmanageable fears about the circumstances surrounding the death (Erna Furman, 1974).

These considerations raise an important question: Is a parent's death invariably traumatic when it occurs in the first years of the child's life? Or is it traumatic only when the child witnesses its occurrence under sudden and/or violent circumstances? In other words, when is the parent's death the cause for intense but normative grief, and when does it lead to traumatic bereavement?

We take the position that the death of a parent, in itself, comprises what Bowlby (1980) called “the trauma of loss” when it occurs in the first 5 years of life, before the child has established an autonomous sense of self that is relatively independent of the parent’s protection. We suggest that premature grief is traumatic in its own right because the child does not have the emotional and coping mechanisms to maintain neurophysiological regulation and to sustain an organized and coherent sense of self while undergoing the grieving process (Hofer, 1996, 2003). The somatic disruptions and the feelings of grief can be so intense that the child becomes overwhelmed by his own subjective experience, and he responds with typical traumatic responses such as reexperiencing, avoidance, affective numbness, and autonomic arousal to any stimulus that may evoke feelings associated with loss. Expressions of grief by the surviving parent and other adults can add to the traumatic response by compounding the child’s perceived threat to the integrity of the self.

The severity of the trauma of loss may be conceptualized along a continuum of traumatic experience that depends on the interplay between the circumstances of the death, whether or not the child witnessed the death, and the child’s developmental stage. At the milder end of this traumatic continuum, the death follows a protracted illness that allows for some anticipatory guidance and leave taking on the part of the dying parent, the child does not witness the death, and the child has some capacity for self-care as well as some prior understanding of the nature of death. Under these circumstances, the traumatic experience consists of an internal collapse in the cohesiveness and continuity of the sense of self at the loss of protection and security that was once afforded by the now deceased parent. At the extreme end of the traumatic continuum, the death is violent and unexpected, the child witnesses it, and the child is at a developmental stage where he is totally dependent on the parent and has no prior understanding of the nature of death. In such a situation, the child is flooded by uncontainable anxiety caused by the sensory overload from the stimuli that accompanied the death, as well as by the inability to comprehend why the parent is no longer available to help assuage these unbearable feelings. Intrusive memories and pervasive traumatic reminders may then maintain the experience of the death that is continually present for the child, interfering with the child’s ability to mourn and bring relative closure to the experience of loss.

A parent's death often leads to drastic changes in family life that may introduce additional stresses in the child's life, placing the child's development at still greater risk (Pynoos et al., 1999). The security of the child's attachment to the surviving parent is often negatively affected under the weight of the external pressures and emotional burdens engendered by the death. For example, the child may blame the surviving parent for failing to prevent the death, whereas the parent may become emotionally unavailable under the multiple stresses involved in mourning while having to attend to drastically altered life circumstances. Changes in family composition may occur. For example, a relative may come to live with the family to help with the crisis; a parent who feels unable to care for the child may send her to live elsewhere; or the parent may begin a new romantic relationship and remarry soon after the death. Bitter custody disputes may ensue, particularly when there are issues of accountability about who is responsible for the death. These and other circumstances lead to changes in daily routine that are particularly stressful for young children, both because they represent a break in predictability and because they remind the child of the unique and irreplaceable ways in which the parent did things while alive. These secondary stresses and other adverse life circumstances have additive negative effects on the child's emotional health, and may lead to a confluence of comorbid conditions, such as traumatic stress disorder, anxiety, separation anxiety, and depression (Rutter, 1985).

Given the complexity of these psychological and situational factors, a best-practices approach to the treatment of bereaved young children needs to incorporate a combination of therapeutic approaches that can be flexibly deployed depending on the circumstances of the death and the child's reaction to it. In this framework, grief and trauma work need to be integrated and calibrated in response to the child's and family's needs (Pynoos & Nader, 1993). The treatment modalities must be multifocal in order to maximize responsiveness to the diverse circumstances that influence the child's emotional functioning. When the parent died under sudden or violent circumstances, clinicians must take care to view the clinical material through two simultaneous lenses: the lens of trauma and the lens of loss. The traumatic circumstances surrounding the death can recede in the child's mind when the anxiety responses are consistently addressed, facilitating the child's work of mourning the loss of the parent (Black, Kaplan, & Hendricks, 1993; E. Furman, 1974).

The set of guidelines presented here describes approaches to the treatment of infants, toddlers, and preschoolers who experienced the death of a parent or other primary caregiver in a range of circumstances. It includes common reactions to loss in infancy and early childhood, specific complications in the grieving process associated with traumatic responses to sudden and/or violent parental death, assessment and treatment approaches, and vignettes illustrating children's responses and clinician interventions. These guidelines are informed by an integration of psychoanalytic theory and attachment theory with interventions influenced by social learning and cognitive-behavioral approaches. The reference section includes basic sources as well as more recent contributions that were helpful in developing the guidelines, including bereavement manuals for the treatment of older children. For the sake of brevity, the word "parent" is used to denote a caregiver with whom the child has a primary attachment relationship, regardless of his or her biological origins. The recommendations may be extended to other forms of early loss, including the death of a sibling or grandparent.

These guidelines are written for clinicians who have experience in treating young children or who are in training to acquire this experience. Working with bereaved infants, toddlers, and preschoolers can take a toll on the clinician's emotional well-being; therefore it is important to establish stable and knowledgeable sources of support. No matter how experienced the clinician, it is best not to undertake the work of treating a bereaved young child and her family in isolation. In deciding whether to treat a bereaved young child, clinicians are advised to assess not only their own capacities but also the institutional support available to them, such as reliable access to supervision or consultation. Although addressed to clinicians for the purpose of therapeutic intervention, components of these guidelines may also be useful for teachers and caregivers seeking to provide emotional support to bereaved children.

The basic premise permeating the guidelines is that the clinician's emotional availability and empathic responsiveness must be grounded in a solid clinical background and a working knowledge of early child development. The course of grief and bereavement is always subjected to wide individual variations, but it is particularly unpredictable in infancy and early childhood because the child's responses are deeply affected by constitutional strengths and vulnerabilities, the quality of surrogate caregiving, and the changing circumstances of the family, including the availability and quality of environmental supports. The variability

of response is even greater when the death was violent and when it disrupted the fabric of relationships within the family. For these reasons, we place less emphasis on recommending specific intervention techniques, and more emphasis on promoting a therapeutic attitude informed by knowledge of developmental principles and the effects of trauma and loss. These guidelines endeavor to instill a state of mind about how to treat early traumatic bereavement rather than to prescribe specific interventions. The clinician's own creativity, experience, and emotional maturity are essential ingredients in using these guidelines to structure what is always a uniquely individual therapeutic effort to weave a joint narrative about a parent's death.