Repairing The Effects Of Trauma on Early Attachment

Alicia F. Lieberman, Ph.D.
Irving B. Harris Endowed Chair In Infant Mental Health
Child Trauma Research Program
San Francisco General Hospital
University of California San Francisco

What Is Mental Health?

“The capacity to love well and to work well”

– Sigmund Freud
What Is *Infant* Mental Health?

The capacity to grow well and to love well

- Experience, express and regulate emotions & recover from dysregulation
- Establish trusting relationships & repair conflict
- Explore and learn

Within the society’s cultural values

(Lieberman; Zero to Three)

An Ecological-Transactional Model of Development

“Development Lasts A Lifetime”

Protective & Risk Factors

“Allostatic load”

*Macrosystem:* Cultural practices

*Exosystem:* Neighborhood & community

*Microsystem:* Family inter-relationships

*Ontogenetic development:* The Individual

(Bronfenbrenner, 1979; Cicchetti & Lynch, 1993; Sameroff, 1993; Rutter, 2000)
An Ecological-Transactional Model Of Development

- Child functioning is shaped by the interplay of risk and protective factors
  - within the child
  - in the environment
- Risk factors co-exist and compound each other
- Risk factors generate secondary stresses
- Likelihood of psychiatric disorder increases with the number of risks

(Lynch & Cicchetti, 1998; Rutter, 1999; Pynoos et al., 1999; Sameroff, 1993)

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Children Need To Be Understood In The Context Of Their Relationships
Self And Environment

“There is no such thing as a baby”
– Winnicott

“Yo soy yo y mi circunstancia”
– Ortega y Gasset

Then, is there such thing as a mother?
Or only a mother and her circumstances?

Risk As A Continuum
From Stress To Trauma

Normative, Developmentally Appropriate Stress
Emotionally Costly (Toxic) Stress
Traumatic Stress

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Childhood Adversity and Minority Status

- Higher poverty rates among minorities
- Adversities cluster when there is poverty
- Impact of adversities is cumulative
- Minority children are more vulnerable:
  - cumulative effect of adversities
  - less access to services

(Oser & Cohen, 2003; Flores et al., 2002; U.S. Surgeon General’s Report, 2001)

Prevalence Of Stressors

- 52.5% of 2-5 years olds in a pediatric care clinic experienced at least one major stressor
- No gender or race differences
- Preschoolers were more likely to experience a major stressor, but 42% of 2-year olds had experienced at least one such event

(Egger & Angold, 2004)
Cumulative Stressors and Psychiatric Disorders

(Egger, 2004)

When Parents Fail To Protect

- 9 Adverse Childhood Experiences (ACE):
  - Emotional, physical or sexual abuse
  - Domestic violence against the mother
  - Household member with mental illness
  - Household member with substance abuse
  - Household member ever imprisoned
  - Neglect
  - Separation from the parents

- Predict 10 leading causes of adult death/disability

(ACE Study, Felitti et al. 1998)
Sources Of Violence Overlap

- Children exposed to domestic violence
  - 15 times more likely to be abused than the national average
  - 30-70% overlap with child abuse
  - At serious risk of sexual abuse
- Battered women
  - Twice more likely to abuse their children than comparison groups

(Osofsky, 2003; Edleson, 1999; Margolin & Gordis, 2000; McCloskey, 1995)
Can Young Children Remember Traumatic Events?

- Implicit memory precedes verbalization
- “Memorability” of event elicits strong emotion
- Retrieval: Verbal children narrate traumatic events from pre-verbal period
- Accuracy of recall versus misunderstanding
  
  (Nelson, 1994; Gaensbauer, 1995; Terr, 1988)

Psychobiology Of Childhood Traumatic Stress

- Chronically elevated levels of stress hormones
- Lower levels of cortisol
    (mood enhancing neurotransmitter)
- Anatomical differences in brain structures related to memory and planning
  - Smaller brain volume, larger fluid-filled cavities, less connective matter

  (DeBellis & Putnam, 1994, DeBellis et. al., 1999a&b)
Traumatic Stress In Infants And Young Children

- Re-experiencing trauma (flashbacks, nightmares)
- Numbing (social withdrawal, play constriction)
- Increased arousal (attention problems, hypervigilance)
- New Symptoms
  - Aggression
  - Sexualized behavior
  - New fears
  - Loss of developmental milestones

(As cited by Felitti & Anda, 2003; Source: CDC)

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The Interplay Of Past And Present: Ghosts In The Nursery

• Repetition of the past in the present
• Repression of the affects associated with early helplessness and terror
• From victim to perpetrator: Identification with the aggressor

(Fraiberg, Adelson & Shapiro, 1975)

Violence As Paradigm Of Ghosts In The Nursery

• Shattering of developmental expectation of protection from the attachment figure
• The protector becomes the source of danger
• “Unresolvable fear”: Nowhere to turn for help
• Contradictory feelings toward each parent

(Pynoos, 1993; Main & Hesse, 1990; Lieberman & Van Horn, 1998)
Impact Of Violence On Parents

- Emotional dysregulation
- Loss of trust in self & others
  - Victim
  - Perpetrator
  - Helpless bystander
- Traumatic reminders: pervasive danger
- Traumatic expectations: getting hurt

Intergenerational Transmission Of Parental Trauma

- Impaired emotional regulation
- Parent and child as traumatic reminders
- Negative parental attributions: “You are bad”
- Traumatic expectations: “You will hurt me”
- Child internalizes parental attributions
Caregiver As Protective Shield Against Risk And Danger

Normative Early Anxieties

- Fear of loss
- Fear of losing love and approval
- Fear of body damage
- Fear of internal badness

Trauma exacerbates all of these anxieties

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Normative Parental Functions

• Protection from danger
  – External
  – Internal
• Caregiving
• Socialization

Treatment Of Early Trauma: Creating Angels In The Nursery

• Giving expression to the traumatic experience
• Putting the trauma in perspective
• Building trust and intimacy
• Practicing joy in everyday pursuits
Individualizing Treatment: Integrated Theoretical Approach

- Developmentally Informed
- Attachment focus
- Trauma-based
- Psychoanalytic theory
- Social Learning processes
- Cognitive–Behavioral strategies
- Culturally attuned

(Lieberman & Van Horn, 2005)

Pillars Of A Therapeutic Attitude

- Notice feelings in the moment
- Find connections between experiences
- Remember the suffering under the rage
- Seek out the benevolence in the conflict
- Offer kindness
- Encourage hope
**Child-Parent Psychotherapy Intervention Modalities**

1. Promote developmental progress using play, physical contact and language
2. Unstructured/reflective developmental guidance
3. Modeling protective behaviors
4. Interpretation: linking past and present
5. Emotional support
6. Concrete assistance, case management, crisis intervention

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**Early Trauma Treatment**

- **Participants:** 75 3-5 year old children and their mothers
- **Location:** San Francisco
- **Randomized controlled trial**
  - Child Parent Psychotherapy
    - Weekly x 50 weeks (mean sessions = 32)
  - Case management and community treatment
    - 73% of mothers and 55% of children received psychotherapy

(Lieberman, Van Horn & Ippen, 2005)
Early Trauma Treatment

- Findings
  - Children
    - Reduced number of posttraumatic symptoms in CPP but not controls
    - Reduced number of behavior problems in CPP but not controls
  - Mothers
    - Reduced number of posttraumatic symptoms for CPP and controls
    - Reduced mothers’ distress for CPP but not controls
      (Lieberman, Van Horn & Ippen, 2005)

Percentage Of Children Diagnosed With PTSD

(Lieberman, Van Horn & Ippen, 2005)
Empirical Support For Child-Parent Psychotherapy

- Five randomized studies with about 500 children and mothers
- Infants, toddlers, preschoolers
- Anxious attachment, child maltreatment, maternal depression, domestic violence
- Range of SES, multicultural samples
- Consistent findings of CPP efficacy
- Measures: Cognitive performance, quality of attachment, quality of child-mother relationship, mental representations, maternal and child diagnoses

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

Percentage Of Mothers Diagnosed With PTSD

(Lieberman, Van Horn & Ippen, 2005)
A Compelling Conclusion

• “The overarching question of whether we can intervene successfully in young children’s lives has been answered in the affirmative and should be put to rest.”

• “However, interventions that work are rarely simple, inexpensive, or easy to implement”.

(From Neurons to Neighborhoods, 2000)

Treatment Is Not Enough: Ecology Matters

Protective & Risk Factors

“Allostatic load”

Macrosystem: cultural practices

Exosystem: neighborhood & community

Microsystem: family inter-relationships

Ontogenetic development: individual adaptation

(Bronfenbrenner, 1979; Cicchetti & Lynch, 1993; Sameroff, 1993; Rutter, 2000)
**Trauma As A Supra-Clinical Phenomenon**

“This ecological-transactional approach, although long recommended, is seldom implemented. ...child trauma is seen only as a clinical phenomenon... This narrow focus must be super-ceded by the ubiquity of trauma as the frequent cause of physical and mental illness, school underachievement and failure, substance abuse, maltreatment, and criminal behavior... we are dealing with a supra-clinical problem that can only be resolved by going beyond the child’s individual clinical needs to enlist a range of coordinated services for the child and the family.”

(Harris, Lieberman & Marans, 2007)

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**What Can We Do?**

- Promote family-friendly policies
  - *child safety net, family leave, childcare*
- Early intervention: “Pre-K, starting at birth for those who need it”*
- Promote inter-system coordination:
  - *early identification and referral*
- Fund training to build and preserve capacity
  - *primary care providers*
  - *childcare providers*
  - *infant mental health providers*
  - *child protection workers*
Translating Research Into Public Policy

Three examples:

- National Child Traumatic Stress Network (NCTSN): Raising the standard of care (SAMHSA)

- Safe Start Initiative: Creating models of community collaboration (OJJDP)

- Court Team: Judicial system-Early Intervention partnership (OJJDP)