TERMINATION AS A THERAPEUTIC INTERVENTION WHEN TREATING CHILDREN WHO HAVE EXPERIENCED MULTIPLE LOSSES

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ABSTRACT: Children who have endured traumatizing events often have a history of prior disruptions and losses which also have been experienced as traumatic. Termination of therapy with these children, therefore, provides a unique opportunity for the clinician to provide the traumatized child and his or her caregiver with a new experience of loss; one that is controlled, predictable, and paced. Through this experience, the child and caregiver can develop a new model for loss, one that permits for losses that are a natural part of healthy growth and change. This article outlines one approach to utilizing termination as an integral component of the therapeutic process with infants, toddlers, and preschoolers and their caregivers. Using a psychodynamic model and working dyadically with the child and the caregiver, termination is approached as a primary intervention, pivotal to the successful treatment of this vulnerable population.

RESUMEN: Aquellos niños que han aguantado eventos traumatizantes a menudo tienen una historia de trastornos y pérdidas anteriores que también han sido experimentadas como traumáticas. La terminación de la terapia con estos niños, por tanto, es una oportunidad única para que el clínico les provea al niño traumatizado y a quien lo cuida con una nueva experiencia de pérdida, una experiencia controlada, predecible y medida. A través de esta experiencia el niño y quien lo cuida pueden desarrollar un nuevo modelo de pérdida, el cual permite que una pérdida ocurra como parte natural de un crecimiento y un cambio saludable. Este ensayo describe un acercamiento para utilizar la terminación como un componente integral del proceso terapéutico con niños pequeños, infantes y aquellos en edad prescolar, y quienes les cuidan. Al usar un modelo sicodinámico y trabajar con la díada del niño y quien lo cuida, la terminación es vista como una intervención primaria, esencial para el éxito del tratamiento de este vulnerable grupo de la población.

RÉSUMÉ: Les enfants qui ont enduré des événements traumatiques ont souvent une histoire de disruptions et de pertes précédentes qui ont aussi été vécues de façon traumatique. L'interruption de la thérapie avec ces enfants, dans ce contexte, offre une opportunité unique grâce à laquelle le clinicien peut donner à l'enfant et à son mode de soin une nouvelle expérience de perte; une expérience contrôlée, prévisible, mesurée et dosée. A travers cette expérience l'enfant et le mode de soin peuvent développer un nouveau modèle de perte, un modèle qui permet les pertes qui sont une partie naturelle de développement sain

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et du changement. Cet article présente une approche pour utiliser l'interruption en tant que composante intégrale d'un processus thérapeutique avec les nourrissons, les petits enfants et les enfants de maternelles et leurs modes de soin. En utilisant un modèle psychodynamique et en travaillant de manière dyadique avec l'enfant et son mode de soin, l'interruption est conçue comme une intervention primaire, cruciale pour le traitement réussi et optimal de cette population vulnérable.

ZUSAMMENFASSUNG: Kinder, die traumatischen Ereignissen ausgesetzt waren, haben of bereits eine Biografie belasteter Erlebnisse und vermehrten Verlusten, die zusätzlich als traumatisch erlebt wurden. Das Ende einer Therapie bietet daher bei diesen Kindern eine besondere Möglichkeit von Klinikern, Kindern und ihren Bezugspersonen erneute Erfahrungen von Verlust, aber diesmal kontrolliert, vorhersagbar und bewusst eingesetzten Setthing, zu erleben. . Durch diese Erfahrungen können Kinder und Bezugspersonen neue Modelle für den Umgang mit Verlust entwickeln, welche es erlauben, Verluste als natürlichen Teil von gesundem Wachstum und Wechsel zu erleben. Der vorliegende Artikel skizziert einen Ansatz, der Trennung als wesentlichen Teil des therapeutischen Prozesses mit Säuglingen, Kleinkindern und Vorschulkindern und ihren Bezugspersonen benutzt einsetzt. Unter Verwendung eines psychodynamischen Modells und der dyadischen Arbeit mit dem Kind und seinen Bezugspersonen, wird Trennung zu einer wichtigen Intervention, die ausschlaggebend für die erfolgreiche Therapie dieser verletzlichen Population ist.

抄録：トラウマとなる出来事に耐えてきている子どもたちは、しばしばそれ以前に混乱と喪失の歴史をもち、それらもまたトラウマとして経験されてきている。したがって、これらの子どもたちとの治療の終結は、臨床家にとって、トラウマを負った子どもとその養育者に新しい喪失の経験を提供するユニークな機会となる。すなわち、コントロールされていて、予測可能で、ペースを守った喪失である。この経験を通して、子どもと養育者は、喪失に対する新しいモデルを作り上げることができる。そのモデルとは、喪失は健康な成長と変化の自然な一部であるということを認めるものである。この論文では、乳幼児と就学前児およびその養育者との治療過程に不可欠な構成要素として、終結を利用するアプローチを概説する。精神力動モデルを用いて、子どもとその養育者と二者関係的にワークしながら、終結は主な介入として、この脆弱な人々の治療の成功への転回点として、アプローチされる。

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INTRODUCTION

Our program at the Louisiana State University Health Sciences Center in New Orleans provides therapy for children ages 0 to 5 years who have witnessed or been victims of violence, or who have been otherwise traumatized. One of the most challenging aspects of treating this population is that most of the children brought in for treatment for an identified, recent trauma are found to have a significant history of prior and concurrent traumas, often both acute and chronic in nature, that were not identified as part of the presenting problem. Indeed, they often face even more traumatic losses during the course of therapy. How these losses and disruptions may complicate the child's clinical course and how this information should factor into treatment planning and, perhaps most significantly, affect and inform the termination process have been the subject of many supervisory and peer discussions.

There have been many studies of the effects of single and multiple stressors on populations, including school-aged children, adolescents, and adults (Gisalson & Call, 1982; Kaufman, 2000; Osofsky, 1999; Pfefferbaum et al., 2001; Pynoos, 1996; Pynoos & Eth, 1984; Terr, 1988), and many worthwhile explorations of working with traumatized children (Carter, Osofsky, & Hann, 1991; Chaffin & Hanson, 2000; Gaensbauer, 1996; Gaensbauer, Chatoor, Drell, Siegel, & Zeanah, 1995; Lieberman, Silverman, & Pawl, 1999; Muir, 1992). Although

there are writings that specifically discuss the effects of multiple losses on very young, traumatized children and how this impacts and should inform their treatment, as well as writings on termination of psychotherapy with older children, we could find no literature specifically addressing the importance of termination with multiply traumatized infants and toddlers and their families. We feel it is a significant gap in the literature, particularly given the dynamic changes in development that define each child's vulnerability to the impact of such losses. It is our hope to begin the exploration of this difficult, but pivotal, component of therapy with this population.

Studies have shown that multiple stressors have a cumulative effect, and therefore can be more detrimental to emotional well-being than can single stressors. For example, in the Rochester Longitudinal Study (RLS), Sameroff (2000) examined the effects of various combinations of multiple risk factors' effects on children's development, following them from the prenatal period through adolescence. He found that "(a)lthough there were statistically significant effects for the single risk factors in the RLS at the population level, most children with only a single risk factor did not have a major developmental problem" (p. 13). Indeed, the study showed that "as the number of risk factors increased, competence decreased . . . (m)oreover, it appeared that the *number* [italics added] of risk factors, rather than their kind was most predictive of outcome" (p. 13). Thus, while combinations of various kinds of stressors were not significant in predicting poorer functioning in children, the number of coincident stressors was reliably so.

While Sameroff (2000) focused on the effects of cumulative risk factors, other researchers and clinicians within the field of trauma have suggested that the impact of a trauma on a young child depends on the cumulative effects rippling out from the primary trauma. This required assessing whether the trauma was acute or chronic in nature. More than a decade ago, Lenore Terr (1991) theorized that the presentation of posttraumatic stress symptoms in children who had suffered a single catastrophic event was measurably different from that of children who suffered repeated traumas, so much so that they warranted dividing childhood trauma into two subtypes: Type I traumas were single, sudden, unexpected traumas, presenting clinically with symptoms of precise memories of the trauma, omens, and misperceptions or distortions. Type II traumas were defined as resulting from repeated traumatic events, often characterized by "prolonged and sickening anticipation" (p. 11). Terr (1991) noted that both subtypes share common posttraumatic symptoms (intrusive memories, repetitive behaviors, trauma-specific fears, and changed attitudes about life, people, and the future); however, symptoms specific to Type II traumas were identified as denial and numbing, dissociation, and rage.

Having established the nature of the trauma as either acute or chronic, and understanding the clinical challenges of each, the next task is to identify the aftereffects of (or the cumulative effects rippling out from) the primary trauma that may result in further traumatization of the child and/or caregiver. In the case of acute trauma, these "ripple effects" would likely be fewer and of shorter duration. With chronic trauma, the clinician may assume that there would be an ongoing potential for "ripple effects" that would impact progress in therapy. These effects were labeled "secondary adversities" by Pynoos, Steinberg, and Wraith (1995). They stated that these effects

increase the risk of initial comorbidity of posttraumatic stress reactions with other adverse reactions. They complicate efforts at adjustment and may interfere with normal opportunities for developmental maturation, or initiate maladaptive coping responses that, over time, may be associated with chronic non-PTSD psychopathology. (p. 77)

Other studies have documented that children who have suffered one traumatic event (i.e., sexual or physical abuse) were far more likely than were controls to be exposed to further potentially traumatizing events (Finkelhor & Dzuiba-Leatherman, 1994). While it is unclear whether the later traumas are truly "secondary adversities," the significantly increased risk for further traumatization does suggest that there may be a causal connection between the primary and later traumas. Regardless, Sameroff's (2000) findings about the adverse effects of cumulative risk factors and other studies (Applegard et al., 2005) that have shown high co-occurrence of some types of trauma (e.g., abuse, neglect, domestic violence) with other risk factors (e.g., poverty, substance abuse, single parenthood, poor education, unemployment, etc.) suggest that young traumatized children are at high risk for developmental difficulties.

Certainly, our clinical observations have been consistent with these findings. We frequently have observed children who display an exacerbation of existing posttraumatic symptoms and/or the presentation of new symptoms when exposed to new stressors. Further, we have found that children who presented to our clinic with a dramatic identified trauma, such as witnessing the murder of a parent, also often lived chaotic, unstable lives before the identified traumatic event. They may have been exposed to community or domestic violence, or may have experienced multiple changes of residence and/or other potentially traumatic significant losses or disruptions. Many continue to endure aftershocks of trauma, as their routines are further disrupted by the ripple effects of the identified trauma. For example, they may be passed from one relative to another after the loss of the primary caregiver, or they may enter the foster care system as a result of abuse or neglect. The child's school or daycare may be changed to accommodate each move, and they may be separated from siblings. The therapist is confronted not only with the direct effects of the identified trauma but also with the episodic retraumatization of the child by his or her family or by the systems that are trying to help the child. Sadly, many of the caregivers we work with still carry the wounds of their own early traumas, traumas which still linger, negatively impacting the caregiver's ability to respond to the child's needs. The child's trauma may rekindle the caregiver's unhappy memories of his or her own past traumatic losses. As Selma Fraiberg (Fraiberg, Adelson, & Shapiro, 1987) so eloquently framed the issue, families are often "reading from the tattered script" (p. 165) their intergenerational ghosts have provided them, unable even to conceptualize, much less enact, a loss that is not traumatic, abrupt, and fraught with crisis. In these cases, the therapist is uniquely challenged to provide the stability, reliability, and support that has been and often is still lacking in the child's and, indeed, the family's life. Trust must be established and maintained, and consistency and reliability must be modeled throughout the course of therapy not only for the child but also the caregiver(s) who may have never before experienced adequate emotional support during experiences of traumatic loss.

The culmination of this reparative relationship lies in the termination phase of treatment, which, if conceived and executed sensitively by the therapist, can provide the multiply-traumatized child and his or her caregiver(s) with what may be their first experience of a nontraumatic loss. For this population, the experience of an emotionally supportive termination phase is an essential component of any effective intervention. Indeed, a well-planned and well-executed termination phase has the potential to be a pivotal intervention for multiply-traumatized infants/toddlers and their families. It can provide them with an essential working model of nontraumatic loss, thus increasing their self-efficacy. Sadly, termination also has the potential to be yet another in a string of traumatic losses, if handled poorly by the clinician. Therefore, it is of the utmost importance that the therapist regards termination as pivotal in supporting the child's foundational development of trust in the stability of future relationships.

With this understanding, termination is initially conceptualized at intake, but also should be continuously reworked throughout the therapeutic process, finding its proper time and method as the relationship develops. If the therapist works with the caregiver to create for the child a controllable, sensitively paced and predictable loss, it can provide the child and the caregiver(s) with a new script—a new way to face and to navigate the losses they will surely face again.

DISRUPTION AND LOSS

For those fortunate enough to have been raised by a loving, consistent, and emotionally supportive caregiver, loss is accepted as an integral, if unhappy, part of life. Healthy relationships are growth-promoting, and growth is inextricably mingled with loss. As infants, we enjoyed the warmth and intimacy of the caregiving relationship, fully experiencing nurturance from and dependence on our primary caregiver. Having successfully navigated this phase and satisfied our need for extended, one-on-one, sensitive interaction, we were able, indeed we were developmentally compelled, to explore our environment, including new relationships. Of course, this evolution involved leaving behind the intense intimacy of the mother–infant relationship. Thus, as we grow, we change, and most change involves some form of loss.

Our caregiver's sensitivity and responsiveness help us form a foundational sense of safety and trust, a secure base that frees us to grow and explore our environment. A healthy attachment relationship teaches the infant that affective experiences do not have to be overwhelming. The child learns that she or he can reliably return to a manageable emotional state, first through caregiver interventions, then dyadically, then ultimately the child achieves affective regulation through his or her own efforts (Carlson & Sroufe, 1995). As we successfully negotiate the intermediary states between developmental stages, we gain the skills needed to cope with these losses. This prepares us for later experiences of unpredictable losses (e.g., death of a pet). Such losses are much more painful and difficult to integrate. The first experience of a sudden, unforeseen loss is devastating to our growing sense of safety and stability. But with developmentally sensitive emotional support from our caregiver, we gain new skills, refine our defenses, and are able to integrate such losses. The children seen in our program are seldom fortunate enough to have had such consistent, supportive caregiving. Often, they are the product of chaotic, haphazard, abusive, and/or neglectful environments. Their early experiences are fraught with frequent, unexpected disruptions in caregiving or insensitive caregiving, resulting in insecure attachment to caregivers and a working model of change as unpredictable and of loss and disruptions as traumatizing.

Given the estimable impact of developmental concerns on how disruptions in caregiving impact a child's ability to cope adequately with losses, the clinician should attend to any such prior experiences during the assessment period, weighing the relative impact each experience may have had on the young child. Relevant experiences in infancy and early childhood include abrupt changes in the primary caregiver, which may be caused by intrafamilial violence, abuse, and/or neglect or may result from the intrusion of external events such as crime or disasters into the infant–caregiver relationship. Other conditions that impact caregiving, such as severe mental illness and substance abuse, also acutely or chronically deprive the infant of the provision of basic care and disrupt the circle of communication so essential to the child's development of a secure attachment to his or her caregiver. For example, long-term substance abuse by the caregiver disrupts the caregiver's ability and desire to interact with their child. At a time in a child's development when he or she requires consistency, sensitive reading of his or her

cues, and supportive responses to basic needs, the resulting periodic emotional and/or physical abandonment may be a traumatic experience for the preschooler. Additionally, developmental delays and medical issues in the child or caregiver also may cause disruptions in care, resulting in a similar effect on the child. While such disruptions cannot be considered losses, they may variably affect a child's ability to cope with loss and should be regarded as factors that require special therapeutic attention within the context of termination.

The next section will explore chronologically the impact of developmental level on a child's experience of loss. Understanding this variable helps the clinician determine whether a loss is inherently traumatizing to a child.

DEVELOPMENTAL IMPACT OF LOSS AND INSENSITIVE CAREGIVING

Sensitive caregiving during infancy supports the child's development of affective regulation. Because the child is yet unable to self-regulate, he or she relies on the caregiver's interventions (e.g., soothing, feeding, rocking) to help him or her cope with noxious stimuli. During the first 3 months, loss of the primary caregiver would be disruptive insofar as the child's routines were changed and needs unmet. After 3 months, loss of the primary caregiver would be a disruption because the child is beginning to form a hierarchy of attachment figures. The child's distress would be reduced if he or she were provided with consistent and sensitive caregiving by a known caregiver. However, if due to insensitive caregiving, routines are disrupted and the cues are no longer understood, if the caregiver is neglectful or abusive, or there is violence and disruption in the home, the infant will struggle to adapt primitively to the new threat in his or her environment. This may result in developmental delays and impoverished emotion-regulation skills.

At approximately 6 months of age, with the onset of focused attachment, loss of the primary caregiver would be potentially devastating to the infant. When this occurs, every effort should be made to keep all other aspects of the infant's life as stable and routine as possible. If possible, the child should be cared for by one of his or her hierarchy of preferred caregivers, enabling the infant to transition his or her primary attachment to another caregiver with as few challenges as possible. As mentioned earlier, the impact of violence in the infant's environment is long-term and can result in learning disabilities, behavior disorders, and other psychopathology in later childhood (Dodge, Bates, & Pettit, 1990; Perry, 1997).

By 12 months of age, the infant's hierarchy of attachment figures interacts with him or her dyadically promoting affective regulation. At this age, violence in the home and/or environment will have serious, long-term developmental consequences. Loss of the primary caregiver would be debilitating for the child at this point due to the depth of dependence on the specific primary caregiver to help him or her self-regulate.

At about 18 months of age, the child has a developed sense of self; however, loss of the primary caregiver at this point would remain devastating to the child for the reasons cited earlier. Helping the child cope would require the same sensitivity to the child's emotional needs and those supportive interventions noted previously.

From age 24 months, the toddler is internalizing attachment relationships and develops a capacity to self-regulate. The toddler seeks autonomy while still craving nurturance and support from his caregivers. These conflicting feelings often result in tantrums and confusion. Discerning interpretations of these behaviors by the caregiver assists the toddler in working through conflicts and resolving fears. Loss of the primary caregiver would be interpreted by

the child as abandonment. Grief and rage would be profound, and the child would be difficult to console. Remaining within the hierarchy of attachment relationships and the maintenance of routines, along with sensitive interpretation of outbursts as expressions of grief and anger, would assist the child through this crisis.

Therapeutic Approach

Our clinical approach is grounded in attachment theory (Bowlby, 1969/1982, 1973, 1988) and supporting research. Our primary intervention method is psychodynamic, nondirective therapy (Axline, 1969). We reserve the latitude to sparingly utilize more directive methods as indicated through our collaborations with the caregiver and through our supervisory and peer discussions of the case. In general, however, our method is to follow the child's lead and to support the caregiver in doing so. We believe that given time, sensitive interpretation, and a safe, holding environment, the child will work through the traumas, reaching out to caregivers for support as needed. The caregivers, in turn, will develop new skills in responding supportively to the child's needs. Our role is to observe and interpret their interactions and support the caregiver through modeling, reflection, and instruction. This method draws on several complementary techniques, including Parent–Child Psychotherapy (Liebermann et al., 1999), Watching, Waiting and Wondering (Muir, 1992), and Speaking for the Baby (Carter et al., 1991).

Assessment

Along with a full biopsychosocial assessment, we do an exhaustive inquiry into all prior and current losses and/or disruptions the child has endured. A developmentally informed understanding of these losses and their meaning to the child is essential both in treatment planning and in education of the current caregiver. Infants and toddlers are often viewed in our culture as unconcerned by or even oblivious to changes in their environments. It is essential that the caregiver is educated about the child's developmental needs and about the emotional and developmental impact of losses on the child. For many of our parents, it is the first time they have truly grasped the extent to which their child was affected by these losses. Assessment also includes an examination of the current caregiver's relationship with the child. The therapist assesses the impact of the child's losses on the caregiver. If the child lost his or her primary caregiver, how is the current caregiver coping with the demands of parenting the child, and how does the caregiver perceive his or her responsibility to the child? Is it an honor to be caring for the child, or is it a burden? The caregiver's perception of the child and of their relationship will play a pivotal role in treatment planning since treatment often involves strengthening the relationship between the child and the current caregiver. An assessment of all of the child's significant relationships is done. Making a genogram that maps these relationships is often helpful. Significant relationships may include any persons who have frequent, extended contact with the child and those who assist the caregiver. The genogram is also helpful in documenting any intergenerational patterns in the child's family. As with all good assessment, this process of information gathering continues throughout the treatment phase, incorporating any new losses. Special attention is paid to anniversary dates of losses. These are often times of great emotional upheaval, unconsciously enacted, which if left unaddressed and unexamined can result in further losses. The therapist is in the unique position to alert the caregiver and the older child of the upcoming anniversary, permitting talk about the loss and the feelings that may be currently arising. This often diffuses the anniversary

effect, but where it does not, it gives the caregiver ample warning of and resources to address any regression or outbursts the child may experience. The Diagnostic Classification: 0–3 Manual (Zero to Three/National Center for Clinical Infant Programs, 1994) is used for most diagnoses in this age group, as it is most relevant to the cases we see.

TERMINATION

Termination of therapy with children and how best to prepare the child for the end of treatment has been only minimally explored in the literature. Our examination of extant literature yielded some useful guidelines. Chazan (1997) conceptualized treatment as an attempt to resolve disruptions in the child's development stemming from the loss of a secure base that the child is unable to contain, "result(ing) in injury to himself and discomfort to his caregivers" (p. 221). This loss results in a change in relationship to the caregivers. Termination then would naturally follow resolution of these disruptions and strengthening of the relationship to the caregivers. We prefer dyadic work with our population, agreeing with Chazan's notion that it is through strengthening the relationship between caregiver and child that healing occurs. We see the therapist's role as collaborator in this process of discovery (or sometimes rediscovery) of the relationship. As such, we attempt to model sensitive emotional support while maintaining clear and appropriate limits with the caregiver and the child. Chazan also stressed the importance of relationship within a healthy termination process: "Along with the amelioration of symptoms, the child and his caregivers are sustained in their relationship, permitting the loosening of bonds to the therapist to occur without negative consequences" (p. 222). Thus, they are able to enact a nontraumatic loss, thereby gaining mastery over earlier traumatic losses.

Kernberg (1991) conceived of events within the therapeutic relationship as potential re-hearsals for termination. Sensitive handling by the therapist of any disruption in that process, such as vacations, illnesses, and holidays, enables the child to progressively develop skills to cope with the loss represented by termination. "Indeed there is no other situation in which the child can so fully explore the experience of separation and loss in all its genetic and current aspects and be aided by someone who is close yet objective" (p. 321). This of course addresses individual therapy, not dyadic therapy; however, it is generalizable to dyadic treatment. As the caregiver is supported through these 'little losses,' they are provided the opportunity to learn how to support the child through more significant losses. Thus, the child gains competence in loss through the relationship with the caregiver.

As noted previously, many of the children we see have difficulty at the ends of sessions. These endings are another "little loss" we use as an opportunity for intervention. The therapist will often provide warnings of the upcoming end of the session, giving the child periodic reminders in the final 15 min that the end of the session is approaching and telling him or her how many minutes are left before it is time to clean up the playroom. This models making transitions in activities a predictable event, which supports the child in being able to accept transitions more readily. Cleanup time is used to transition the child out of play and back into daily life. The therapist attempts to engage the child in helping with cleanup, rewarding cooperation with appreciation and praise. If the child begins to act out, the therapist responds supportively, verbalizing the child's anger and frustration about having to stop doing fun things and leave the playroom. Many children fear leaving behind the toys, believing they will not be there when they return. The therapist reassures the child that he or she will return to the playroom

to play with the toys again. It is important to set limits regarding safety should the child become aggressive or engage in dangerous acting out. Otherwise, the child can often be redirected by asking him or her to pick out a few toys he or she wants to be saved for the next appointment. The child is given a small basket to hold these items and may even carry it to the therapist's office for "safekeeping." It is very important that when the child returns for the next session, the basket is where he or she left it, with the treasured toys in it. Although this may seem something a toddler would forget over the intervening week, we have learned by the look of delight on the children's faces when they see their basket that they realize we have held and protected their treasures. In this way, we are symbolically holding and protecting the child him- or herself. Over time, the child comes to trust both the therapist and the therapy process as reliable and predictable. We also honor any harmless rituals that the child initiates, such as turning off the lights him- or herself as he or she leaves the room or parking a push car in a certain corner each week at the end of the session. These rituals foster the child's sense of predictability and safety within the session. As time passes, many children voluntarily discontinue these rituals as their confidence in the predictability of their environment increases. As the child comes to trust that we will be respectful of his or her needs and protective of his or her safety, the child's confidence increases and the ability to tolerate transitions represented by the ends of the session improves.

Sugarman (1991) supported the notion of tapering sessions during termination with the younger child to assist them in accepting and adapting to the loss over time. He also explored the importance of the therapist adapting to the child's developmental awareness of time and giving the child a vocabulary to express his or her loss, though interpretation of affect. We have found both techniques useful with our population. Traumatized children and their families often know no other way to express their anger and fear at perceived abandonment than to behaviorally express their feelings by "acting out." Often, by interpreting the child's feelings, we have found ourselves touching on the caregiver's feelings as well. This can be a wonderful opportunity to join with the caregiver. It may be the first time their feelings have been accurately "read" and sensitively responded to by another. Through this experience of being understood and supported at a time of great emotional vulnerability, the caregiver then becomes more able to offer this same opportunity to the child. Tapering sessions also has proven useful with those families who have the most difficulty with issues of abandonment. In these cases, we take particular care to leave the door open for future "booster" sessions as the family needs them. This is an essential reassurance for those whose primary experience with ending relationships was through "burning their bridges." Such caregivers may reenact their experiences by unilaterally discontinuing treatment. In those cases, we make efforts to reach out to them to permit a more gentle letting go of the relationship; however, the "ghosts" sometimes win, and we do not hear back from these families. For those who complete the termination process and are offered follow-up sessions as needed, we have found that they seldom call for such sessions. It seems that simply knowing that they can return gives them the emotional support they need to move forward on their own.

We agree with Lieberman et al. (1999) that our client is not the child nor is it the caregiver, but *the relationship between* child and caregiver. So our primary efforts at preparation for termination with infants and toddlers are directed at the caregiver who, through the relationship with the infant and by successfully navigating the loss of the continued contact with and support of therapist, rewrites the script of loss for the child. The timing of termination when working with infants is collaborated on with the caregiver. There are instances where an older child is developmentally able to participate in this decision making. If so, he or she is part of the collaboration. The therapist initially looks for signs that the child and caregiver are ready

to cease treatment: Have the identified problems been successfully addressed? Has the child attained significant progress towards developmental norms? Has the child developed skills in self-regulation? Is his expression of affect consistent with the child's emotional state? Is the child using more developmentally appropriate methods of expression? Are these expressions clear and direct, or are they ambivalent or misdirected? Has the caregiver demonstrated increased sensitivity to the child's cues? Is the caregiver appropriately responsive to these cues?

Once we have determined that the child and caregiver are able to relate more effectively with each other, and that each has developed skills in both understanding and in being understood in relationship to others, it is time to introduce the topic of termination. This is often brought up with the caregiver first to gauge their receptivity. If caregivers react to termination with fear or distress, we examine this further with them to determine if they perceive the gains they have made to be dependent on the relationship with the therapist. If the caregiver discloses such a misperception, the therapist will work with him or her to increase awareness of the essential role he or she played in the child's recovery. When the caregiver is ready to proceed, termination will be raised in session with those children who can talk. Whereas with older children the date of termination is often a collaboration, this is not so with infants and toddlers. The therapist and parent may collaborate on the date when possible (Sadly, it was not in our case study.), and care will be taken to give toddlers at least a few weeks' warning of the end of therapy. If the therapist feels it to be helpful, termination will be staged, with sessions farther and farther apart—initially once a week, then every other week, then finally once a month at termination—to assist the child in transitioning through the loss of the therapist. The final session is generally marked with a party, usually involving cupcakes or doughnuts and a small gift. If the child has demonstrated a history of significant difficulty with losses or separation in the past, the therapist may have the caregiver take a snapshot of the therapist and child together to be used as a transitional object.

CASE EXAMPLE

Presenting Problem

Randall was brought in by his paternal grandmother. His presenting problems were sleep disturbances, tantrums, aggression towards others, and outbursts of screaming and crying "help me, help me!" that lasted for up to 1 hr. Randall's paternal grandmother and step-grandfather, the Smiths, were his legal guardians at that time, and he resided with them. No other relatives lived in the home. Mrs. Smith married Mr. Smith when her son, Randall's father, was 10 years old. Her first husband, Randall's grandfather, was a substance abuser and had no contact with the family after divorcing Mrs. Smith.

History

Randall was born prematurely. Although both of his parents had extensive histories of substance abuse, there was no report of prenatal substance exposure. Immediately following his birth, Randall spent 1 month in the Intensive Care Unit due to a respiratory issue. Because there was little contact between the Smiths and their son, little was known about Randall's prenatal care, delivery, and the postnatal period; however, Mrs. Smith reported that Randall visited them often, and was generally clean, healthy, and well-fed, although he became distressed at having to return home and, when he was old enough to speak, would beg to live with them. Mrs. Smith said

that Randall's parent's "straightened up" before he was born, but then relapsed when Randall was approximately 2 years old. Randall was cared for by his parents in his home from the time of his discharge from the hospital at 1 month of age until he was 28 months old. His parents' resumption of substance abuse at this time likely had a negative impact on their caregiving. Approximately 4 months later, Randall was enrolled in daycare, which he reportedly attended 5 days a week.

Little was known about Randall's caregiving during his first 3 years of life. When Randall was 33 months old, while he and his mother were out of the house, his father was killed in a fire. Little was known of what Randall saw or knew about his father's death. When Randall's step-grandfather, Mr. Smith, went to visit Randall approximately 1 month after this event, he found Randall with his mother, who was unconscious and unresponsive from drugs. Mr. Smith called Child Protection Services, and he and Mrs. Smith were given temporary custody of Randall at that time. Mrs. Smith called our agency 1 month after gaining custody of him, asking for counseling for Randall due to the behavior problems outlined earlier. Since Randall's removal, his mother had made no attempt to contact him.

To gain a fuller picture of Randall's current level of functioning, the therapist asked about his routines and behaviors since moving in with his grandparents. Mrs. Smith reported that Randall appeared to have no established routines when he came to live with them. Initially, Randall fell asleep at 2 a.m. and arose in the late morning. He had tantrums regularly and had frequent sleep disturbances, including nightmares and getting up from his bed to check that the Smiths were still there.

Assessment

At this point, we assessed Randall's family history with a focus on his many disruptions and losses. The primary identified loss was the sudden and violent death of his father. Within 1 month of the death of his father and the loss of his home when Randall was nearly 3 years old, he moved with his grieving, substance-abusing mother to a new home. He was then removed from his mother's care due to neglect, placed with his grandparents, and changed daycare facilities. That this 35-month-old child was presenting with behavior problems was not surprising to us. It was noted that there was an intergenerational "ghost" of parental substance abuse haunting Randall's nursery. The fact that Randall's grandmother had very little knowledge of his birth and early development complicated the picture, and spoke to another intergenerational pattern of emotional cutoff: After their divorce, Mrs. Smith had no contact with her first husband, Randall's biological grandfather, and she also had had very limited contact with her son. Now Randall's mother had abandoned him, having made no attempt to contact Randall for over 1 month. That Mrs. Smith provided little detail about these traumatic events spoke to the possibility of secret-keeping and denial of feelings so often present in families coping with substance abuse.

Diagnostic Considerations

The symptoms with which Randall presented certainly could be consistent with a diagnosis of traumatic stress disorder (DC: 0–3; Zero to Three, 1994) resulting from the single, extreme trauma of sudden, violent parental loss. But given Randall's history, these symptoms also could be related to preexisting disorders of relationship. This possibility was supported by the reports of Randall's extreme distress on separation from his grandparents after visits that occurred well

before his father's death. Randall also spent the first month of his life in a hospital, and this could place him at further risk for disorders of relationship and/or regulatory disorders.

Plan of Treatment

The therapist decided with the grandmother that dyadic therapy would be pursued since the loss of Randall's father also was the loss of Mrs. Smith's son. While the Smiths demonstrated signs of normal grief, they were not sharing their feelings with Randall, believing they were protecting him. Working through the loss together with Randall, if the grandparents were able to do so, would serve not only to help them integrate the loss but would build and strengthen the growing relationship between Randall and the Smiths. Further, as they processed their own feelings of anger and pain, they would be more emotionally available to Randall, who needed their support. It was agreed that sessions would be weekly and would be attended by Randall and his grandmother since Mr. Smith served in the military and could not attend regularly.

Intervention

The therapist spent the next several sessions building rapport with Randall and his grandmother. She noted that while Randall was very affectionate with his grandparents, Randall experienced very little enjoyment in play. Randall demonstrated minimal eye contact and engaged in isolated play in the sand tray. He spent most sessions absorbed in repetitive, aggressive play themes enacted within the sand tray while the therapist either commented on his play or talked with Mrs. Smith. Over the ensuing sessions, several themes emerged in Randall's play, including selecting only aggressive animals with visible teeth, feeding, fighting, larger animals swallowing smaller ones, and hoarding of toys. In one session, he spent several minutes hiding toys around the room so that "no one else can play with them." Randall had difficulty with separating at the end of the session, as do many of our population.

The therapist also noted that Mrs. Smith's parenting style was loving, but authoritarian. Mrs. Smith admitted to feeling overwhelmed by Randall and spoke of his current behaviors as "difficult" and "demanding." The therapist addressed this by empathizing with Mrs. Smith's struggle to adapt to her new role and by educating Mrs. Smith about the impact of loss on young children, focusing on children's tendency to act out as an expression of their anxiety, by explaining behavioral methods of discipline, and by modeling emotionally supportive ways of responding to disruptive behaviors. Having identified safety and stability as major issues for Randall, the therapist made reassuring him of these her primary goal. The Smiths were encouraged to give Randall frequent assurances of their role as his protectors. Mrs. Smith was able to identify several strengths in Randall, including being athletic, smart, fun, and outgoing. These positive associations were built upon by the therapist in her work with Mrs. Smith, including encouraging her to praise Randall for his strengths and accomplishments. Mrs. Smith was an apt student, and although there were periods of backsliding to old habits, little by little she developed greater empathy in her interactions with Randall.

Approximately 3 months into treatment, due to her coming departure from Louisiana State University, the therapist initiated termination with Mrs. Smith and Randall by beginning to discuss their progress in treatment thus far. A month prior to leaving, the therapist first discussed her upcoming departure with Mrs. Smith. The therapist offered to transition Randall to a new therapist if Mrs. Smith preferred. Mrs. Smith accepted this offer, and so the subject of changing

therapists was raised with Randall in the following session. The therapist reassured Randall in each subsequent session that he would continue to come and play in the office with a new therapist. He was permitted to ask questions and express his own wishes about this. Randall stated that he wanted to keep coming to the office and that he did not want the therapist to leave. The therapist empathized with his feelings while maintaining clear limits. Mrs. Smith also responded supportively to Randall, reassuring him that she would continue to bring him to the sessions. The final session was marked by a small party with food and a small gift for Randall. Randall struggled to master his fear of abandonment by yelling at the therapist in the middle of the final session, "We don't like you! You need to leave!" This outburst lasted approximately 30 min. The therapist responded supportively, verbalizing Randall's feelings of anger at her for leaving him and sadness as well. He stopped abruptly and crawled into her lap, and they talked together about her leaving until the session ended. At that time, Randall helped clean up the room, and he and Mrs. Smith said goodbye and left without distress. Note that Randall's termination/transition in therapy corresponded with the anniversary of his parents putting him into daycare for the first time—another period of transition and loss.

Randall and Mrs. Smith resumed sessions with the new therapist approximately 1 month later. This therapist seamlessly resumed the techniques (sand tray, reassurance of safety, education, and modeling) utilized by the initial therapist. About a month later, Randall's mother began calling Randall at his grandparent's home, stating that she wanted to regain custody of Randall. This worried the Smiths, and the subsequent emotional upheaval in the household combined with his mother's frequent calls threw Randall into emotional turmoil. His prior symptoms, which had abated somewhat, resumed with ferocity. Themes of parental loss emerged through Randall's sand tray play as well as reenactments of prior traumas. In one session, Randall talked about a puppy he was playing with being sad "because his daddy died." Randall had great difficulty at the ends of sessions, throwing sand at the therapist and Mrs. Smith, throwing toys, and resuming highly aggressive themes in his play. The therapist and Mrs. Smith reassured Randall more actively that he was safe and that the Smiths would protect him. The therapist also increased verbally interpreting Randall's feelings for him. While this escalated his aggression within the session, he did better at home, and over time became more able to self-regulate. Randall began a new theme of pouring sand, which appeared to have a calming effect on him. He would frequently return to this in future sessions as a way to soothe himself when anxious. Some months later during the holiday season, Randall's aggression once again increased. The therapist connected Randall's recent surge in aggression with the death of Randall's father 1 year earlier and with the first holiday season for the Smiths without their son. The therapist encouraged Mrs. Smith to talk about her son in Randall's presence during the session. Mrs. Smith was able to do so, with the immediate effect of a marked decrease in behavior problems across settings for Randall. Randall also began to use human figures in his play for the first time. In subsequent sessions, Mrs. Smith's interactions with Randall also softened. She now sat near him in play, talking soothingly to him and patting him on the back when he began to signal anxiety or distress in his play, demonstrating increased sensitivity to his need for emotional support. Mrs. Smith reported that Randall had begun talking about his father and the fire at school, indicating to the therapist that Randall was internalizing his grandmother's permission to verbally process his father's death. In his play, Randall now assembled families.

Shortly after this, near Randall's birthday and the anniversary of his parent's relapse into drug use, Randall's mother committed suicide. The therapist sought supervision with the team. She expressed concern because she had been planning to begin termination. Now, given this

sudden death, she felt she needed to focus on helping the family cope. We were all challenged by the enormity and complexity of this traumatic loss, and discussed the relative merits of raising the issue of termination versus postponing this discussion. It was decided that the therapist would focus on helping the family through this crisis before initiating discussions about termination. The therapist discussed Randall's conflicted feelings about his mother. Given his feelings and the abrupt and violent nature of his mother's death, her loss would be yet another in a devastating series of losses for this child. It was agreed that Randall must be told about his mother's death, and that honesty would be an important component in this. We struggled with a developmentally appropriate way to talk to a now 4-year-old child about his mother's suicide. We also were painfully aware of the timing of this loss, so closely linked with other significant dates for Randall. We developed a plan that the Smiths should tell Randall about the death on their own, or within session if they chose. It was decided that Randall should be told only that his mother had died, reserving any explanations until he asked for further information. We provided developmentally sensitive explanations of how she died as suggestions for the Smiths, should they need them. When the Smiths told Randall about the death of his mother, they reported that he listened closely and looked like he might cry, but did not.

Termination Phase

Mindful of the coming end of her internship, and confident that the Smiths were coping better with Randall's mother's death, his therapist sought supervision regarding how and when she should initiate termination discussions with Randall and his grandparents. Given the many disruptions with which they were already coping, we struggled over this unfortunate timing, but decided that it was better to permit the family time to make their decision to transition or terminate therapy when the therapist departed in 1 month. It was noted that Randall and the Smiths had made substantial progress in treatment, having now completed over 20 sessions with their second therapist. Randall demonstrated an increased ability to verbalize his feelings and to use methods such as pouring sand to help self-regulate when overwhelmed. Therefore, it was felt that they had made progress and developed sufficient new skills to permit them to successfully transition out of therapy, if they so chose. We were concerned that the family's many recent losses would make such a transition difficult. The therapist first discussed termination with Mrs. Smith by telephone. With her approval, the topic was raised with Randall during the next session. Randall was withdrawn during this session, making little eye contact, but his affect and expression of anxiety were appropriate. Notably, he spoke for the first time of his parents being dead, signaling his feelings of abandonment by the therapist. Mrs. Smith spontaneously went to Randall and patted him on the back, stating she would protect him and keep him safe.

   Over the remaining sessions, Randall gave fuller expression to his anger about the therapist's departure, which was sensitively interpreted by both the therapist and Mrs. Smith. Randall then calmed himself by pouring sand. In their final session, Randall lined up dolls on the roof of the play house and then tipped the house, causing the dolls to fall. The therapist caught them, which delighted Randall, so they repeated this theme several times. Randall then took one male doll and threw it gently to the therapist, who caught it. She then transitioned to playing with a ball. Randall accepted this, and they played with the ball for the remainder of the session. He was able to say goodbye to the therapist before leaving and hugged her.

DISCUSSION

While initiating termination with the Smiths much earlier would have been this team's optimal goal, a family crisis requiring immediate therapeutic intervention superseded that ideal. Although certainly not ideal in its execution, this case is presented to highlight the many challenges unique to each case that can influence when and how termination is executed. In this case, the awkward intrusion of the end of an internship twice interfered with the therapeutic relationship, but skillful handling of the termination phase permitted the client to transition successfully.

With each termination, Randall's coping improved. This is attributable to the therapists' direct interventions with Randall and her indirect interventions, working to improve the Smith's understanding of and sensitive response to Randall's struggles with his feelings about his many losses. At the end of treatment with his second therapist, Randall was able to terminate with decreased emotional distress. His response to this final session demonstrated his increased coping skills and an improved sense of his world as safe and supportive. As Randall began to experience this support through loss, loss became a tolerable, if unwanted, event—one which he could successfully and safely navigate, confident he could turn to his grandparents for support if needed. One key component to Randall's ability to accept and adapt to the losses in his young life was the remarkable work done by Mrs. Smith, who undertook the challenge of caring for this wounded child. Her capacity to adapt so fully to Randall's needs was remarkable. Another essential component was the ability of both therapists to sensitively interpret and work through Randall's experience of loss of their relationships. At a time when none of the other losses he endured were predictable or paced, termination was. Randall knew that these losses were coming, granting him a sense of control over the events and fostering his sense of stability and reliability of his environment. Randall also was encouraged to fully and openly express his anxiety and anger about these losses. Through full exploration of all of his ambivalent feelings about his therapists' departures, during which he was sensitively emotionally supported by the therapist and Mrs. Smith, he increased his sense of safety. This was fostered by Mrs. Smith's reassurances that she would look after him and protect him, enabling Randall to extend his trust to this relationship as well. The result of these efforts was Randall's newfound ability to say goodbye to his second therapist with a normative level of discomfort and distress.

In his transition/termination session with his first therapist, Randall was able to verbalize and act out his ambivalence about her departure by first shouting at her "We don't like you . . . you have to leave!" then crawling into her lap to talk about her leaving. His fears still overwhelmed him, but Randall was developing an appropriate verbal and behavioral vocabulary for those fears, and he felt supported in his expressions of those feelings. This permitted a relatively seamless transition to his second therapist. Through the difficult, but excellent, collaborative work this therapist and Mrs. Smith did together, by the time this therapist terminated, Randall could play out his feelings with significantly reduced aggression. Randall's ability to help clean up at the end of the last session and to hug the therapist and say goodbye to her demonstrated his hard-won mastery of his old fears.

SUMMARY

Termination with traumatized children and their caregivers presents a unique opportunity. As therapists, we are challenged to use the ending of the therapeutic relationship as a method of intervention. When children have suffered multiple losses, the effect of even a single new loss can be crippling. Developmental milestones can be lost, and the child's behavior may regress

as he struggles to find some sense of safety in his world. Loss for these children has usually been accompanied by threat and disruption, so how do we, as therapists, work with the child and caregiver to rewrite the script of traumatic loss? One way to do so is to help the child and caregiver experience a loss that does not threaten or disrupt—one that is predictable, paced, and controlled. This then has been our effort: To utilize termination as a primary intervention tool, not as simply an endnote to therapy. As seen in the case provided, where loss is repetitive and traumatizing for the family even during the treatment phase, how we address termination with the family and how we support them through the termination process is of utmost importance, and may provide a pivotal healing element in the child's treatment.

FUTURE DIRECTIONS

It is our hope that this exploration of termination as a primary therapeutic intervention in work with children who have suffered multiple losses will spur further exploration into this area. As we have noted, there is very little literature regarding the importance of termination with traumatized infants, toddlers, and preschoolers—indeed, with children in general. In-depth explications of developmental considerations regarding termination for this age group, for example, are beyond the scope of this article; however, such a topic would make a welcome addition to the paucity of literature available. Research exploring the relative benefits of differing termination techniques also would be an invaluable contribution. Further and more extensive qualitative research regarding children's perceptions of therapy, with a focus on termination, would add to the knowledge base as well. A fuller understanding of the meaning and significance of aspects of the therapeutic process to these children and their families is needed, so that we are better equipped to respond adequately to their many needs.

REFERENCES

Applegard, K., Egeland, B., van Dulmen, M., & Sroufe, A.L. (2005). When more is not better: The role of cumulative risk in child behavior outcomes. Journal of Child Psychology and Psychiatry, 46(3), 235–245.

Bowlby, J. (1969/1982). Attachment and loss: Vol. 1. Attachment. New York: Basic Books.

Bowlby, J. (1973). Attachment and loss: Vol. 2. Separation: Anxiety and anger. New York: Basic Books.

Bowlby, J. (1980). Attachment and loss: Vol. 3. Loss: Sadness and depression. New York: Basic Books.

Bowlby, J. (1988). A secure base: Parent–child attachment and healthy human development. New York: Basic Books.

Carlson, E.A., Sroufe, L.A. (1995). Contribution of attachment theory to developmental psychopathology. In Developmental Psychopathology. Volume 1: Theory and Methods, Oxford: John Wiley and Sons.

Carter, S.L., Osofsky, J.D., & Hann, D.M. (1991). Speaking for the baby: A therapeutic intervention with adolescent mothers and their infants. Infant Mental Health Journal, 12(4), 291–301.

Chaffin, M., & Hanson, R.F. (2000). Treatment of multiply traumatized children. In R.M. Reese (Ed.), Treatment of child abuse (pp. 271–288). Baltimore: Johns Hopkins University Press.

Chazan, S.E. (1997). Ending child psychotherapy: Continuing the cycle of life. Psychoanalytic Psychology, 14(2), 221–238.

Dodge, K.A., Bates, J.E., & Pettit, G.S. (1990). Mechanisms in the cycle of violence. Science 250(4998), 1678–1683.

Finkelhor, D., & Dzuiba-Leatherman, J. (1994). Children as victims of violence: A national survey. Pediatrics, 84, 413–420.

Fraiberg, S., Adelson, E., & Shapiro, V. (1987). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant–mother relationships. In L. Fraiberg (Ed.), Selected writings of Selma Fraiberg (pp. 164–196). Columbus: Ohio State University Press.

Gaensbauer, T.J. (1996). Developmental and therapeutic aspects of treating infants and toddlers who have witnessed violence. In J.D. Osofsky and E. Fenichel (Eds.) Islands of Safety. Zero to Three Bulletin, 16(5), 15–20.

Gaensbauer, T.J., Chatoor, I., Drell, M., Siegel, D., & Zeanah, C.H. (1995). Traumatic loss in a one-year-old girl. Journal of the American Academy of Child and Adolescent Psychiatry, 34(4), 520–528.

Gisalson, I.L., & Call, J.D. (1982). Case report: Dog bite in infancy: Trauma and personality development. Journal of the American Academy of Child Psychiatry, 21(2), 203–207.

Kaufman, J. (2000). Exposure to violence and early childhood trauma. In C.H. Zeanah (Ed.), Handbook of Infant Mental Health (pp. 195–207). New York: Guilford Press.

Kernberg, P.F. (1991). Termination in child psychoanalysis: Criteria from within the sessions. In A.G. Schmukler (Ed.) Saying goodbye: A casebook of termination in child and adolescent analysis and therapy (pp. 321–337). London: Analytic Press.

Lieberman, A., Silverman, R., & Pawl, J.H. (2000). Infant–parent psychotherapy: Core concepts and current approaches. In C.H. Zeanah (Ed.), Handbook of infant mental health (pp. 472–484). New York: Guilford Press.

Muir, E. (1992). Watching, waiting and wondering: Applying psychoanalytic principles to mother–infant intervention. Infant Mental Health Journal, 13(4), 319–328.

Osofsky, J.D. (1999). The impact of violence on children. The Future of Children: Domestic Violence and Children, 9(3), 33–49.

Perry, B.D. (1997). Incubated in terror: Neurodevelopmental factors in the "Cycle of Violence." In J.D. Osofsky (Ed.), Children in a violent society (pp. 124–149). New York: Guilford Press.

Pfefferbaum, B., Nixon, S.J., Tivis, R.D., Doughty, D.E., Pynoos, R.S., Gurwitch, R.H., & Foy, D.W. (2001). Television exposure after a terrorist incident. Psychiatry, 64(3), 202–211.

Pynoos, R.S. (1996). Exposure to catastrophic violence and disaster in childhood. In C.R. Pfeffer (Ed.) Severe stress and mental disturbances in children (pp. 181–208). Washington, D.C.: American Psychiatric Publishing.

Pynoos, R.S., & Eth, S. (1984). The child as witness to homicide. Journal of Social Issues, 40(2), 87–108.

Pynoos, R.S., Steinberg, A.M., & Wraith, R. (1995). A developmental model of childhood traumatic stress. In D. Cicchetti and D. Cohen (Eds.) Developmental psychopathology, Vol. 2: Risk, disorder and adaptation (pp. 75–95) [Series on Personality Processes]. New York: Wiley.

Sameroff, A. (2000). Ecological perspectives on developmental risk. In J.D. Osofsky and H.E. Fitzgerald (Eds.) WAIMH Handbook of Infant Mental Health (Vol. 4, pp. 1–29). New York: Wiley.

Sugarman, A. (1991). Termination of psychoanalysis with an early latency girl. In A.G. Schmukler (Ed.) Saying goodbye: A casebook of termination in child and adolescent analysis and therapy. London: Analytic Press.

Terr, L. (1988). Case study: What happens to early memories of trauma? A study of twenty children under age five at the time of documented traumatic events. Journal of the American Academy of Child and Adolescent Psychiatry, 27(1), 96–104.

Terr, L.C. (1991). Childhood traumas: An overview. American Journal of Psychiatry, 148(1), 10–20.

Zero to Three/National Center for Clinical Infant Programs. (1994). Diagnostic Classification: 0–3: Diagnostic classification of mental health disorders of infancy and early childhood. Arlington, VA: Zero to Three.