

Inclusive In-Classroom
Psychoeducational Intervention
for Special Needs Preschool Children

Reflective Network Therapy



A Summary of Benefits and Advantages

Gilbert Kliman, MD



Distinguished Life Fellow of the American Psychiatric Association and Board of Psychiatry and Neurology, Life Fellow and Diplomate of the American Academy of Child and Adolescent Psychiatry, Certified Psychoanalyst for Children, Adolescents and Adults, Diplomate, American Psychoanalytic Association, Diplomate, American College of Forensic Examiners, Fellow, American College of Psychoanalysts

Kliman Diagnostic and Therapeutic Preschool Service

A division of The Children's Psychological Health Center, a nonprofit agency

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Reflective Network Therapy
For Special Needs Preschool Children

within an inclusive preschool:

The Kiwi Preschool

573 Summerfield Avenue, Santa Rosa, CA

Treatment conducted by Gilbert Kliman, MD

Kliman Diagnostic and Therapeutic Preschool Services

www.childrenspsychological.org

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About Reflective Network Therapy and Gilbert Kliman, MD

Geoffrey Fletcher is the Chairperson of our nonprofit agency's Board of Directors. He shares some information from his long standing, hands-on dedication to special needs children in this capacity for The Children's Psychological Health Center. He also is a personal example of the ever growing professional interest in replicating Reflective Network Therapy (RNT) since the publication of Dr. Kliman's book comprehensive book about the method: Reflective Network Therapy in the Preschool Classroom, Kliman, G. (2011) University of America Press, Lanham, MD.

Geoffrey Fletcher discusses Reflective Network Therapy and Gilbert Kliman, MD:

Gilbert Kliman, MD has applied and trained others to use Reflective Network Therapy (RNT) as an interdisciplinary application of educational and psychoanalytic information and collaboration. He has proven that psychodynamically trained therapists and teachers can help preschool children with psychiatric disorders much more effectively as a team in the classroom than they can by working separately. A strong indication of agreement among his professional colleagues is the fact that, as of this writing, the Michigan Institute of Psychoanalysis has begun training at least more six therapists in Reflective Network Therapy in their own Walnut Lake Preschool, our nonprofit agency's most recently affiliated service site, which is currently still under Dr. Kliman's supervision for replication of RNT. This preschool is already reporting IQ gains and global mental health improvements among its patients.

Since his days as an Interdisciplinary Fellow in Science and Psychiatry at the Albert Einstein College of Medicine, Dr. Kliman has favored hard psychometric outcome data. Already reported, in Dr. Kliman's book about the method (Kliman, G. 2011) is the fact that children's Full Scale IQs commonly increase one or two standard deviations after only a year of Reflective Network Therapy. Research results now show that 95% of RNT-treated preschool children who are testable typically make significant CGAS gains, and this has included severely autistic children who were also severely retarded. When a window of time opens up, he plans to publish a second edition, as additional outcome data and applications have accrued from new service sites.

Earlier in 2014, the meta-analysis of a multi-site study carried out over 49 years was completed. One objective was to see how well the children who were treated with RNT sustained their IQ rises by retesting them. The comparison and control children (treated by other methods) were also retested. The results are truly extraordinary. In the "Research Results and Outcome Data" section of this presentation, Dr. Kliman provides background and discusses the meaning of this study in detail. (You can also read more on our website: www.childrenspsychological.org)

Gilbert Kliman, MD is an innovative, pioneering, collaborative, fruitful and, apparently tireless contributor to cognitive and mental health research, public health and public education. He created this life changing and literally real life space application of the potent method called Reflective Network Therapy. Our Board of Directors believes that combined results of interdisciplinary teamwork inherent to the method demonstrate clinical and cognitive results with a systematic quality unmatched by other therapeutic methods for treating special needs children, while providing a cost-effective option and other advantages, as graphed here; in comparison charts in Dr. Kliman's book, (Kliman G., 2011) and on our agency's website.

—GEOFFREY FLETCHER, Chairperson, CPHC Board of Directors

Looking Back and Looking Forward: Armed With a Powerful Method

Reflective Network Therapy was originally known as The Cornerstone Therapeutic Preschool Method, when Dr. Gilbert Kliman first designed and deployed it to help stressed and traumatized children. It was invented in 1965 at The Center for Preventive Psychiatry in White Plains, New York, (one of several nonprofit entities founded by Dr. Kliman over the years). The treatment was quickly found to be remarkably helpful for children with autism spectrum disorders as well as for traumatized children and those preschoolers newly arriving in foster family homes. Since 1965, Reflective Network Therapy has helped more than 1,700 developmentally and emotionally disordered children.

Reflective Network Therapy (RNT) has since been significantly developed by Dr. Kliman and used by more than 25 teacher-therapist teams in a variety of preschool settings from New York to San Francisco, Seattle, Detroit, Boston, San Mateo, Oakland, and Buenos Aires.

Readily individualized, the method has been adapted for children with attention deficit disorders, oppositional defiant disorders, post traumatic stress disorders, anxiety disorders, reactive attachment disorders, and conduct disorders, as well as for traumatized children and children with autism spectrum disorders. Reflective Network Therapy is a particularly powerful method for developmentally challenged young children on the autism spectrum, helping them to develop empathy, relate to family and peers, and grow intellectually. Almost all initially IQ testable and later retested preschool patients had statistically significant IQ rises at the end of a school year. Regardless of diagnosis, children treated with RNT achieve clinical gains: mental health improvements and cognitive improvements. The IQ rise is very orderly in its relation to the number of in-classroom treatment sessions.

In May of 2014, Dr. Gilbert Kliman presented Reflective Network Therapy and the findings of a 49-year long multi-site study to the Association Internationale Interactions de la Psychanalyse in Paris. The work included treatment of 1700 of disturbed preschoolers. Among them were 680 preschoolers on the autism spectrum. All were treated right in their own classrooms with this well-tested therapy.

Videotapes of treatments studied for a school year show observable clinical progress among most of the children. Third-party researchers in eight programs administered IQ tests to 79 of the children, including 31 who were on the autism spectrum, at the beginning of treatment and again a year later. All but one of the 79 twice-tested children showed IQ gains, with an average gain of 15 points. Some of the highest gains were among the 31 autism spectrum patients and, among all diagnoses, those seen three to five times a week.

The data have been subjected to comparisons with other methods, as well as to small controlled and larger comparison studies. The outcomes were of high statistical significance. Dr. Kliman further reported:

“Several projects related to Reflective Network Therapy’s IQ gains are in motion. There is a presumed enhancement of mirror neuron functions. With that hypothesis, Reflective Network Therapy is being studied at other sites, particularly at the Michigan Psychoanalytic Institute by Nancy Blieden PhD, in Cambridge Massachusetts by Professor Alexandra Harrison, MD, and by Linda Hirshfeld at the Ann Martin Center in Piedmont, CA. Another application is an extension of age range for using Reflective

Network Therapy with middle school and high school patients who have learning disorders. This application is being carried out by Sandy Ansari, an Education Specialist.

A new research effort underway is a close study of treatment videos. We have an archive of over 300 treatment hours. We are slicing a view of these videos into 30 second segments and judging them using more than 100 observable behavioral criteria, looking for short term correlates with long term outcomes.

Commenting on benefits and financial consequences, Dr. Kliman remarked “This treatment gives powerful help to these children, their families, and the budgets of their schools.”

[Dr. Kliman’s reference to cost savings for schools is supported in a report on a six-year application of Reflective Network Therapy in public school special education by Jay Parnes, Ed.D. which is included in this material. See: Efficacy of the Method: RNT Evaluated by Professionals, page18.]

Dr. Kliman was awarded a prize for lifetime professional leadership in treatment of autistic and other preschoolers at a joint meeting of the Parisian Psychoanalytic Society and the American College of Psychoanalysts (May, 2014). He is also the recipient of the prestigious Dean Brockman prize for lifetime achievement in Psychoanalysis and Psychiatry, (2012). Increasingly concerned about the spiraling incidence of autism and related disorders, Dr. Kliman presented the results of his multi-site treatment outcome study to the American Psychoanalytic Association meeting in Chicago (June, 2014). Professor Alexandra Harrison, MD presented the findings at the 14th World Association for Infant Mental Health (WAMI) in Edinburgh (June, 2014). Medical Press, an online resource, ran a news item “Breakthrough using unique therapy for children with autism spectrum disorders” (July 2014) which begins “Researchers have reported a surprising finding about a unique treatment of autism spectrum disorder: a large and reliable IQ rise.”

Dr. Kliman commented: “We were not as surprised as others, but were happy to have additional hard data confirming and amplifying the extent of what we have been seeing for so many years in the child patients while following them for sustained IQ rises. They show continued rises in IQ after treatment; they get better, they get smarter, and they are ready after Reflective Network Therapy to grow and continue to thrive in a world of loving and learning.”



A 2014 OVERVIEW OF REFLECTIVE NETWORK THERAPY BY GILBERT KLIMAN, MD

I am delighted to have already begun using Reflective Network Therapy with special needs children at a typical preschool which is happy to include our services: the Kiwi Preschool and Child Care Center in Santa Rosa. We are already in the process of preparing to train new teacher-therapist teams for additional applications in Sonoma County. The model of mental health service within the real life space of a preschool classroom is an important one for public health. Atypical, developmentally and psychiatrically challenged children benefit from acceptance into typical peer groups where they can develop social skills. The more typical children become more altruistic and compassionate. Communities can also save immense amounts of taxpayer dollars by not having to set up segregated special preschools.

Concurrently, our nonprofit agency has established affiliated service sites around the country, where educator-therapist teams (fully trained by senior staff of the Children's Psychological Health Center) continue helping traumatized children, children with autism spectrum disorders, serious emotional disorders, and a host of other conditions which make it difficult for a child to focus, concentrate, communicate and learn, or which make children unable to interact with peers, parents and other adults in healthy ways and resistant to learning. Our busiest such site is in a suburb of Detroit, at the Walnut Lake Preschool run by the Michigan Psychoanalytic Center.

For children with serious emotional, developmental and cognitive disturbances, effective treatment early in life is essential to fully support two precious human functions: loving and learning. Reflective Network Therapy accomplishes both, combining psychotherapy and educational activity with the intersubjective and interactive power of a small social network: the child patient, the child's peers in the classroom, the teacher, the therapist and the parents.

Everything happens in the classroom, including psychotherapy sessions. That simple fact is so essential to the inclusive nature of the method that, in this document you will find iterations and variations on the statement that therapy and learning take place very well in the same real life space: in the midst of all the play, social interaction and educational activity of the real life space of the classroom.

Learning becomes based in part on intensive exercising of positive self-perceptions experienced through in-classroom and team-guided family relationships. The term "network" also takes into account respect for the value of an interdisciplinary and multi-generational team. Reflective Network Therapy is deliberately designed to create and harness a network of children, parents, teachers and therapists, with mental and emotional mirroring and reflections among all of them. This readily occurs right in the children's real life classroom space. Rather than focusing on whether the child's behavior is socially acceptable or on task, this method quickly generates internal rewards, motivation for social and cognitive tasks and develops skills which are emotionally positively charged by interpersonal transactions.

The child's interpersonal relational problems with parents and other children that come up in the moment are seen in the real life space of the classroom. Here and now problems can be addressed therapeutically in the immediacy of the classroom moment, before the child forgets or denies his emotions – not a week later in an office.

Because the ability to mentalize and the capacity for empathy are needed for cognitive development and mental health, Reflective Network Therapy techniques are uniquely structured into routines in the classroom. These routines provide many hundreds of

opportunities per year for modeling naturally arising empathy and exercising mentalizing on a daily basis. Uniquely, this method provides each child pupil-patient a short psychotherapy session multiple times each week, optimally: every school day, as we are now doing in Santa Rosa where we treat challenged children in the midst of normal children.

At the heart of this work, is a close collaboration of psychoanalysts and educators. Instead of simply supervising, the child's therapist is an active in-classroom partner of the teacher; he or she is working in the midst of the educational process. Because the psychotherapy treatment can be done in 15 to 20 minutes right in the classroom, and is done for each child-pupil multiple times per school week; and, because each individual therapy session is bracketed by briefing and debriefing sessions in which the child patient, the teacher, and the therapist all actively participate, there are a few thousand structured opportunities for the two disciplines to learn from each other over the course of a single school year. Rich activation of the mirror neuron systems by Reflective Network Therapy can be seen in videography of actual treatment sessions. In some tapes, one can see the child literally mirroring the analyst's postures and head movement rhythms. A long term, multi-site study has shown a strong correlation between the number of sessions and clinical outcomes. We think that the large number of therapy sessions over the course of a year has a lot to do with how rapidly RNT patients achieve strong clinical gains: improvements in mental health, and cognitive improvements, including rises in full scale IQ. Reflective Network Therapy creates a powerful synergy between in-classroom psychological treatment and inclusive preschool education.

As you go through this document, you will notice that parental insight, input and involvement is regarded as one of the pivotal components of RNT. It is important to us that parents feel supported and heard. Parents of challenged children deserve that. Parents are also the first and deeply valued experts on the subject of their own child who know things and notice things on a daily basis, which only they can readily reveal.

Only parents may know the answer to some important unasked questions. The treatment team relies on parents to let us know what happens when the child is not in school: significant changes in emotional states, problems or changes at home, or a surprising departure from a child's usual positive or negative behavior and preoccupations. Intensive parent guidance and support is an essential part of the program. We know how difficult it can be for parents to attend to the many demands of caring for a child with special needs. Together we help the child become an equal partner in her or his own treatment as the heart and focus of our reflective network.

In my book about the method, I explain that the two sets of professionals appear to function better together than separately. Teachers and therapists appear to deepen their knowledge of their individual patient-pupils because of the many hundreds of hours per year of observational inputs from their in-classroom colleagues.

I have had the privilege of working with amazing teachers in all sorts of preschool settings, including those for homeless children in a Salvation Army service in San Francisco and the Morningsong Shelter in Seattle. Teachers in those difficult life spaces have amazed me with their enthusiasm, commitment, and psychological insights. They experienced the value and the remarkably positive impacts of our interdisciplinary work with the children, including that RNT softened children's resistances to learning and redirected them emotionally and cognitively towards learning, and that they became receptive to learning. In some settings, the in-classroom growth of the teachers as well as the children was startling.

Together, educators and therapists, team by team, took the method's deceptively simple techniques, principles and practices and started something bigger than we expected. All

over the country, service site by service site, we saw the clinical and cognitive gains replicated many times.

This document is an introduction to the method, including citing our outcome data with some discussion of the fact that the method has been scientifically studied and proven by: outcome data collected for nearly 50 years; passing scientific thresholds, and, by being successfully replicated by others. We believe there is evidence that RNT is a more effective psychotherapy for preschoolers than other methods. The results are dose-related; and, that the method produces results more rapidly than other methods. The results include large cost savings, which we show the results here in method-comparison charts. See: “Benefits of Reflective Network Therapy,” “Reflective Network Therapy Compared with Other Methods,” and “Research Results and Outcome Data.”

Better communication, better impulse control, empathic responsiveness and an very high incidence of full scale IQ increases are a few of the benefits of Reflective Network Therapy which enrich the lives of children *and* their families. Such wonders as cessation of bouncing among foster homes, or leaps in IQ do not occur overnight, but certainly they materialize much more rapidly and reliably than with other well-studied methods. Significant mental health and cognitive gains regularly occur by the end of one school year of treatment, often sooner. Many severely disordered children have continued to benefit greatly from a second year of treatment. There is some evidence that even when treatment stops the benefits continue to grow, as in the case of Dorian whose IQ rose from untestable to 80 three years later, then 100, then by age twelve was at 149 (See her self-disclosed video on our web site and her autobiography in my 2011 book).

In a meaningful sense, Reflective Network Therapy treats the whole child by connecting the meanings and pieces of his here and now life into the psychodynamics of a reflective social network within the preschool classroom. No child among the 1700 children treated with RNT over the years has ever needed a one-on-one behavioral aide in the classroom after the first few days; and previously administered psychotropic medications are almost always discontinued after the first few weeks.

— GILBERT KLIMAN, MD

WHAT IT IS – HOW IT WORKS

Reflective Network Therapy is a deliberately synergistic combination of preschool education with in-classroom psychological treatment for emotionally and developmentally disordered children who are two to seven years old. The method is carried out by a network that includes a psychodynamically-trained therapist, teachers, children's peers and family members. Intensive psychotherapy takes place exclusively within the learning and play activities of the classroom, focusing on one child at a time. Children with mild to moderate autism as well as children with other or multiple diagnoses routinely achieve mental health gains, develop cognitively and routinely become able to transition successfully into regular public school classrooms after treatment. Children are never pulled out of class for individual therapy; it takes place right in the classroom. The child's here-and-now feelings, behavior, symbolic expressions and responses to other children and classroom events are all opportunities for therapeutic action and become the subjects of in-classroom therapy sessions.

This section describes some unique aspects of Reflective Network Therapy, and shows how interpersonal exercises can occur hundreds of times in a school year. It is versatile. We have found that these exercises are well suited to influence the brain and mind of an autism spectrum disordered child as well as the brain and mind of a child with a serious emotional disorder. Rich activation of the mirror neuron systems in the child patients treated by this method may account for their measurable IQ rises and mental health gains.

Reflective Network Therapy is an evidence-based psychological treatment method. RNT outcomes have been published in peer-reviewed journals. It harnesses small social networks to help individual children within real life spaces, such as preschools. It works for traumatized young children, as well as those with mild to moderate psychiatric disorders and autism spectrum disorders. Young children we have helped have most commonly presented with: autism spectrum disorders, attention deficit disorders, reactive attachment disorder, oppositional defiant disorder, post traumatic stress disorder, anxiety disorders and depressive disorders.

The small social network therapeutically activated by RNT is comprised of a classroom team of parents, normal children in the classroom, child pupils who are patients, their classroom teachers and a classroom therapist. This interactive network is dynamically engaged with each child, one at a time in the classroom, every day the class meets. The network's intersubjective reflections organize and semantically encode each participant's theory of the child's own mind and to some extent of the minds of all the others in the classroom.

The child's classroom peers are a vibrant part of this network. Everything happens in the real life space of the classroom, and takes advantage of what comes up between and among the children both as educational and therapeutic opportunities for growth.

RNT techniques include: individualized psychotherapy sessions for each child right in the classroom; teacher to therapist briefings before each therapy session and therapist to teacher debriefings after each therapy session. Each briefing and debriefing enlists the child patient's participation. Parent involvement is supported by weekly parent guidance. The child is not pulled out for psychotherapy. In no other method does the child's treatment take place exclusively within the learning and play activities of their classroom groups.

The RNT preschool classroom is a uniquely psychoanalytically informative instrument for the psychotherapeutic processes. Unlike pull out therapy in which a child is removed from real life space for individual therapy, RNT is deeply integrated into the child's learning space as an interactive social setting. Everything takes place within the learning and play activities of the classroom an early childhood educational process and classroom group.

Every day, the treatment team takes advantage of many opportunities to consider immediate evidence of the child patient's emotional and cognitive deficits, strengths and symptomology. Indicators of distress, acting-out, impending crisis, conflict, resistance and transference are psychotherapeutically addressed when they occur. During frequent psychotherapy sessions conducted within the preschool classroom, the child patient's on the spot expressions, behaviors, interactions with others, her or his interest in and use of objects during play, responses to stimuli, and current emotional states are responded to in the moment.

The method has regularly produced rapid mental health gains for seriously disturbed, developmentally delayed and traumatized young children. Gains include positive behavioral changes, improved relational skills, and substantially expanded learning

capacity. These are reflected in the “CGAS” or Child’s Global Assessment Score. Even more objective are resulting rises in IQ. Regardless of diagnosis, statistically significant IQ rises occur routinely.

Each child pupil who is also a diagnosed patient is treated with parental permission and with the cooperation of his public or private school or day care center.

Each child has a psychotherapy session every day of school, usually at least three times a week, right in the classroom, for 15-20 minutes. These short but frequent sessions go on within the classroom in the midst of classroom educational activities of all kinds. The sessions are witnessed, shared and inwardly or outwardly reflected on by everyone in the classroom, right in the real life space of the classroom, using the themes, symbolic expressions and behaviors which arise naturally in this setting.

The child’s psychotherapist intensely focuses on and attunes to each child in turn, for about a quarter an hour at a time. Empathic attunement by the therapist is responded to by the patient’s identification with that process. During that attunement, the therapist offers interpretations. Interpretations are the therapist’s tactful verbalization of her or his own reflections about the child’s feelings, and behavior, especially the therapist’s thoughts about what the child is doing and thinking in the here and now of the classroom, and what has caused those actions and thoughts. Children’s resistances to education, refusal of affection, and inhibited or inappropriate socialization are interpreted on the spot, to the full extent the psychotherapist finds useful.

The content of the therapy sessions varies as greatly as the individual children vary. Content may include a full range of psychoanalytically useful material such as talk, play, fantasies, dreams, interpersonal dramas, art work, responses and the therapist’s verbalized explanation of the meaning of a the child patient’s remarks, dreams, memories, experiences, and behavior (interpretations). If other children show interest, they can participate in all aspects of an index child’s session, provided they allow that child to lead the play and talk. Parents are often in the classroom and are welcome for the periods the parent’s presence allows and promotes the child’s use of the process.

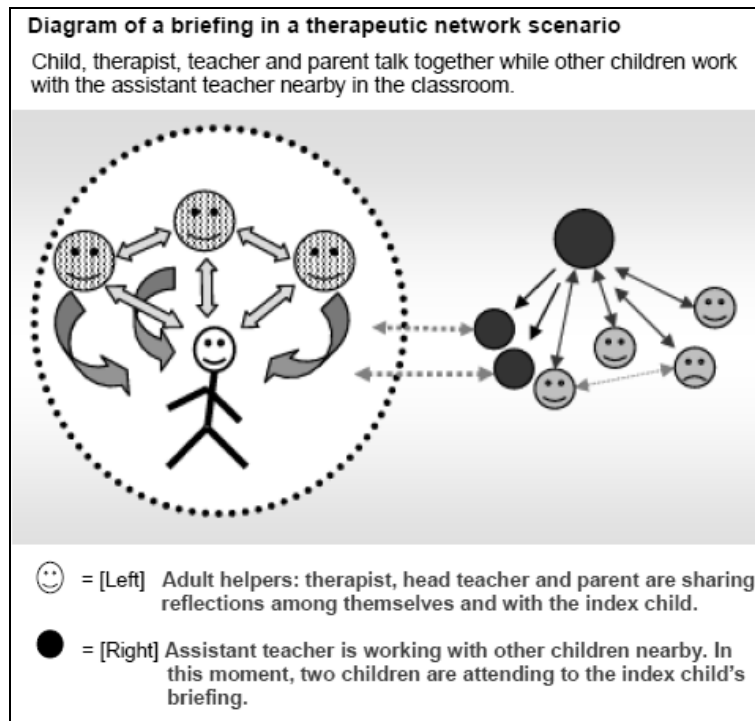
At least two times each day, each child hears directly from the network of helping adults what they think and understand about what is happening in the child’s behavior and play. Adult conversations about a child patient in the classroom are done in the child’s presence. The network reflects about the child in predictable and specific ways, including joint adult-child briefings and debriefings before and after each therapy session and at other spontaneously arising times throughout the classroom day. These conversations are structured around the natural events of the classroom. From these conversations, the child patient learns something about how others think about her or him and what she/he expresses or does. This creates multiple daily opportunities for the child to exercise and develop the capacity to independently reflect on her or his own thoughts, feelings and actions.

Reflective Network Therapy briefings are a structured sequence of interactive reflective and empathy-developing communications given during conversations. The child patient is encouraged to be an active participant in every briefing:

- When a child is brought to school each day, parents take a moment to brief the teacher. This briefing informs the treatment team about what might preoccupy the child before engaging in schoolwork and psychotherapy on that day. They might mention new events in the child’s life, any current behavior or something the child recently expressed.

- Before a child's therapy session, the teacher and child brief the therapist about what the child and family have been doing. Parents also participate in this briefing when they are present. The adults might comment on an interaction just observed between the child and other children in the class. The constant daily briefings before in-classroom individual therapy sessions immediately augment the therapist's access to important themes and behaviors based on the teachers' observations.
- After the 15-20 minutes of individual therapy, the child and therapist close with a debriefing. Together they tell the teacher together about the contents of the psychotherapy session.

Teachers expand the psychotherapist's horizons. The teachers and therapists meet as a team for 90 minutes each week, often viewing a recent videotape of their work, and always sharing the teachers' many hours of classroom behavioral observation. The teachers are expected to greatly amplify the knowledge the therapist gains in the daily therapy sessions.



Parents are essential to the treatment. They are encouraged to be in the classroom, especially, but not only, during the early weeks of a child's treatment. Parents regularly receive a 45 minute guidance session in private with the head or assistant teacher each week except that once a month their parent conference is with their child's RNT therapist. This guidance conference includes the opportunity to give and get feedback about the child's current behaviors, preoccupations and progress. One-on-one behavioral aides are not used. However, a child's existing aide is welcome to come at the beginning of a child's treatment. Behavioral aides are rarely required after a few days. In preschool classrooms where all the pupils are patients, six to twelve children work best, with one therapist and usually two teachers for six or eight special needs children. The adults in the classroom include one therapist and one head teacher with one teacher's aide.

BENEFITS OF REFLECTIVE NETWORK THERAPY: A SUMMARY

Reflective Network Therapy helps children achieve:

- ❖ Greater receptivity to giving and receiving affection
- ❖ Increased vocabulary and improved communication skills
- ❖ Access to their capacity for empathy and empathic expression
- ❖ Ability to think about their own feelings, wishes, beliefs, behavior, and expressions, as well as those of others
- ❖ Greater understanding of self and others
- ❖ Improved sociability
- ❖ Increases of appropriate engagement in interactive activities
- ❖ Greater capacity for impulse control
- ❖ Transformation of behavioral symptoms into dialogue and play
- ❖ Positive behavioral changes
- ❖ Reduction of resistance to learning
- ❖ Readiness to learn and ability to develop and sustain focused attention on the educational work of the classroom
- ❖ Statistically significant rises in IQ.
- ❖ 95% of IQ testable children have sustained IQ rises

Beneficial practices and techniques imbedded in the architecture of the method which reliably produce these positive outcomes include:

- ❖ Intensive psychotherapy takes place exclusively within the learning and play activities with a psychotherapist working in the classroom, making it possible for the child patient to get therapy multiple times per week.
- ❖ Intensive interactive collaboration between the teacher and therapist team in the classroom on each child's behalf informs and enhances the work in each professional's domain.
- ❖ Rather than isolating the child for psychotherapy, RNT actively includes the child's peers in the classroom, providing at least a few thousand opportunities for the therapist to witness and address sociability and communication issues over the course of one year of treatment.
- ❖ Rather than needing to rely upon anecdotal reports or previous testing and psychological evaluations, the teacher has not only the current diagnostic psychological, mental health and cognitive test results, but also the benefit of the psychotherapist's input in the classroom, plus regular 90 minute conferences with the psychotherapist to discuss the child patients' current status, needs and problems.
- ❖ The RNT method uses follow-up testing for an objective gauge of mental health changes and cognitive development at regular intervals.
- ❖ The high frequency of psychotherapy sessions with Reflective Network Therapy, the high frequency of the child's exposure to psychoanalytic interpretations and participation in specialized reflective network

techniques results in significant improvements more rapidly than with other methods.

- ❖ The child experiences the interactive teamwork of the adults in the reflective network as a small world of more people who care about and focus on her or him more of the time, powerfully promoting feelings of being important and being supported in interesting ways. This is especially true when the child witnesses and participates in structured briefings multiple times each school day.
- ❖ Short 15-20 minute psychotherapy sessions are bracketed by briefings which are therapeutic, and their power is cumulatively amplified by the high frequency of both the briefings and the therapy sessions.
- ❖ Briefings, debriefings and the sharing of real experiences probably exercise mirror neurons, modeling, stimulating, and exercising empathy, thinking, and verbal as well as nonverbal meaningful communication.
- ❖ During psychodynamic briefings *and* in daily 15-20 minute psychotherapy sessions, *on the spot* interpretations of the child's expressions and behaviors by the therapist are possible in the child's real life space of the classroom *precisely because* the method is truly interdisciplinary, conducted exclusively in the midst of the learning, play, social interaction and behavior of a preschool classroom, with teacher-therapist-parent collaboration.
- ❖ During psychotherapy, the therapist in the classroom verbalizes for the child what the child patient is doing and his own reflections about what the child may be thinking or demonstrating with verbal or nonverbal expressions, raising the child's awareness and promoting the child's own mentalizing. The therapist also verbalizes her/his own reflections about the child's feelings and behavior.

All these interpretations are made in the child's here and now of the classroom. Children's resistances to education, refusal of affection, and inhibited or inappropriate socialization or behaviors are interpreted for the child immediately, making the work more impactful for and more meaningful to the child.

- ❖ Reflective Network Therapy is a fully inclusive method, such that all the peers in the classroom contribute to the reflective network, and their positive and negative contributions become the material for therapeutic work with each child patient. Peers quickly accept that the child patient who is the index child of a therapy session has the say about who gets to participate; they know they will have their turn soon and that they will be gently asked to attend to another activity if they can't accept an index child's refusal of their participation.
- ❖ A mixture of developmental abilities and behavioral characteristics can be accommodated, including some children who are treated for

preventive purposes, such as in response to bereavement or other presumably major traumas.

General strengths and advantages of Reflective Network Therapy:

- ❖ Siblings of severely disturbed children have been also been helped by Reflective Network Therapy. Emotionally healthy foster children and children of staff have also been welcomed into RNT classrooms.
- ❖ Parents get significant support and share insights, including during weekly guidance conferences with the teacher and monthly conferences with the child's psychotherapist.
- ❖ RNT reduces children's ongoing psychological damages in situations of domestic stress and helps prevent post-traumatic stress disorder.
- ❖ It is a proven method for seriously emotionally disturbed and/or pervasively developmentally disordered young children.
- ❖ RNT is more cost-effective than methods commonly used; approximately one sixth of the usual costs for treatment of autism are needed when using RNT.
- ❖ RNT helps children during and after catastrophic events. The method can be focused as psychological first aid using a derivative of Reflective Network Therapy based on the RNT manualized Personal Life History Books. The PLHB method employs psychoanalytically informed guided activity workbooks to help trauma-impacted children of any age.

MENTAL HEALTH GAINS AND COGNITIVE GAINS: WHEN, WHERE AND HOW LONG?

What is the optimal time to start Reflective Network Therapy?

Reflective Network Therapy is intended to be initiated during preschool and kindergarten, before the children start first grade, and before they may have been chronically ill for several years.

How long does the program last?

The process can be continued for as long as it helps, but is typically continued for one or two school years. Groups of RNT parents and children have continued to find the method positive and productive in after-school groups well beyond preschool. Typically, children with serious emotional disorders treated with RNT have significant mental health gains within a year. Mental health *and* cognitive gains are produced faster by the RNT method. This factor reduces the treatment timeline and therefore reduces the extension of all costs.

INTENSIVE SUPPORT FOR PARENTS: GUIDANCE AND CONSULTATION

Weekly Guidance Conferences with the Teacher Monthly Guidance Conferences with the Psychotherapist

- ❖ **Sharing information, observations, and recommendations**
- ❖ **Learning about your child's engagement with the curriculum**
- ❖ **Receiving support and guidance for your ongoing efforts**
- ❖ **Opportunities to share insights and ask questions**

All of the briefings that take place in the classroom every day not only help the child learn and help teacher and therapist know what is going on for your child; they also build a body of shared knowledge about the child that advances treatment and educational processes discussed during parent guidance conferences. Your child's therapist will be in the classroom working with your child on a daily basis and may be available to participate when you brief the teacher about your child and with your child. When you and your child arrive at the school each day, we ask that you mention anything seems important including significant family events or incidents, recent behavior, anything about what was going for your child that morning, recent behaviors or expressions. This sharing of information takes only a few minutes, if that. Sometimes, it's "Mary had a hard time last night. She cried and screamed a lot after the dog chewed up her pink bunny. The next day it might just be: "Mary was especially quiet this morning. I think she may be tired."

CONFERENCES WITH THE THERAPIST: Your monthly conference with your child's psychotherapist is very important for both you and the therapist. We will do our best to schedule these at times which are most convenient for you.

CONFERENCES WITH THE TEACHER

The teacher and the therapist share briefings in the classroom with your child and about your child multiple times every school day, including talking with the child before and after psychotherapy sessions in the classroom. The teacher will have rich material to discuss with you in weekly parent conferences from her or his own observations including while working with your child on the educational curriculum. During these weekly meetings the teacher will update you about what your child has been working with in the classroom; offer guidance about how you can support or reinforce what is taught in the classroom; request your input and hear your concerns.

WHEN YOU ENROLL YOUR CHILD

Application Forms –Typically, a parent might be given these forms:

- Child Patient Registration
- Developmental History Questionnaire
- Permission for release of Medical, Mental Health and School Records
- Emergency release for treatment
- Health history by parent
- Permission–Release for Videotaping

Additional or different forms may be selected for you, depending on your child's condition, or concerns you may have expressed about your child, or what diagnoses are in your child's history. Some forms may be given to you to complete when you bring your child in for diagnostic testing and/or psychiatric evaluation.

Permission–Release for Videotaping

- Videotaping interviews is an important tool for the subsequent psychiatric evaluation of your child. The psychiatrist will often review such videotapes and may have them transcribed to augment impressions and notes taken during evaluative interviews.
- Video of individual psychotherapy sessions within the play and teaching context of the preschool classroom are often very revealing. These may be studied by the psychotherapist as he or she identifies and works with your child's treatment themes.
- The videos may be shared with the child's teacher for discussion of concerns that may impact learning, and for illustrating information about the child's growth and progress in psychotherapy which furthers the teacher's deepening understanding of your child's special needs and may suggest teaching approaches that may work well with your child.
- The optional Permission–Release for Videotaping form specifies that such videography is limited to purposes of education, training and research. Such uses require Confidentiality Agreements from the professional permitted to view these videos. The child's name is changed on any videos used for training and/or research purposes. No child's name and no other personal information which could identify your child is ever used.

Insurance forms and fee schedule Fees for treatment are on a sliding scale based on income. We will help you complete insurance or Medi-Cal forms.

Diagnostic testing and psychological assessment

- ❖ Psychological testing, cognitive assessment, mental health assessment and a psychiatric evaluation will help determine your child's current mental and emotional health, and her or his current cognitive ability and development.

A clinical psychologist, who is very experienced in working with special needs children, will help your child work through a battery of psychological assessment instruments targeted to the needs of your child and assemble and discuss the results in a psychological assessment summary for review by the doctor who will perform the psychiatric evaluation. Two particular psychometric instruments are used to assess your child's current overall mental health and cognitive ability and development. Follow-up testing using these same measures will quantify the cognitive and mental health outcomes of treatment at the time of the second and later follow-ups:

WPPSI-IV: If your child is testable, we will administer the Wechsler Preschool and Primary Scale of Intelligence - Fourth Edition (WPPSI-IV) (designed for children from age two years, six months to seven years, seven months). This test will provide a baseline measure of your child's current cognitive development.

CGAS: The Children's Global Assessment Scale (CGAS) enables us to assess your child's current mental health as it is expressed in degrees of functionality in behaviors and interactions in different life contexts. This test gives a reliable snapshot of your child's mental health at the time of testing. This assessment is considered a valid measure of overall mental health and the overall severity of mental disturbance.

Psychiatric evaluation and diagnosis

Using your signed multipurpose Permission for release of Medical, Mental Health and School Records, we will have submitted individual requests for copies of records from your child's medical and mental health providers, and from any daycare, preschool or kindergarten your child previously attended. We may or may not have received your child's mental health records by the date scheduled for your child's psychiatric evaluation. Whether or not your child already has received a mental health diagnosis or multiple diagnoses, on the autism spectrum, attention deficit hyperactivity disorder, reactive attachment disorder, or any other serious emotional disorder or impediment to learning, we will want to conduct an independent psychiatric evaluation. Prior to the psychiatric evaluation, the doctor will have reviewed the results of diagnostic testing and summary report provided by the clinical psychologist. In addition to verifying whether or not prior diagnoses continue to be evident, and sufficient, the psychiatric interview with your child will help identify initial therapeutic themes for further exploration as well as initiate the therapeutic relationship.

A parent or guardian will need to accompany the child to this evaluation and often is interviewed with the child before the child is interviewed alone. The parent is also interviewed separately (without the child being in the room) usually on the same day.

Acknowledgment: You will be provided a copy of our "Notice of Privacy Practices for Protected Health Information" with an associated acknowledgment form for your signature.



**EFFICACY OF THE METHOD
RNT EVALUATED BY PROFESSIONALS
WHO HAVE EXAMINED RNT WORK AND OUTCOME DATA**

Jonathan Cohen is the cofounder and president of the National School Climate Center (formerly the Center for Social and Emotional Education). He is adjunct professor in psychology and education at Columbia University, adjunct professor in education at City University of New York and a practicing clinical psychologist and psychoanalyst. Cohen has worked in and with K–12 schools for over 30 years in a variety of roles: as a teacher, program developer, school psychologist, consultant, psycho-educational diagnostician and mental health provider. Cohen authored the first chapter of *Psychodynamic Perspectives on Working with Children, Families, and Schools*, (M. O'Loughlin, 2013) in which he notes that that The Cornerstone Project in San Francisco (established and directed by Gilbert Kliman, MD to deliver Reflective Network Therapy services to cognitively and emotionally disordered preschoolers) was a founding member of the Alliance of Psychoanalytic Schools. In this publication, Dr. Cohen discusses Reflective Network Therapy. Note that CPHC officially changed the name of our method from The Cornerstone Therapeutic Preschool Method (also known as The Cornerstone Method) to the more descriptive name, Reflective Network Therapy in 2007.

**Promoting Children's Healthy Development and Ability to Learn
Past and Current Partnerships between Educators and Psychoanalytically
Informed Mental Health Practitioners**

BY JONATHAN COHEN, PHD

Kliman and his colleagues were the first group of analysts to operationally manualize, and make both retrospective and prospective psychoeducational studies of their efforts. Statistically significant findings include educationally and clinically impressive results of the interdisciplinary treatment (Hope, 1999; Zelman, 1985 & 1996; Kliman, 2006). IQ gains average one to two standard deviations among fifty-two twice-studied children, while sixty comparison and control children show no such gains. Among foster children an additional measure has been used for Cornerstone patients: transfer rates among homes. In a study of thirty foster children in the program transfer rates were reduced to zero over the course of a year, compared to 25 percent a year in comparison populations (Kliman, 2006; Kliman & Schaeffer, 1984). Replication and training for others to carry out the method is now occurring in two sites (Cornerstone Buenos Aires and The Ann Martin Center, Piedmont, CA). A manual and illustrative videos are available without charge from Kliman.

The Cornerstone method provides interdisciplinary education and treatment for emotionally disturbed or developmentally disordered children ages three to six years. Within a therapeutic or special education classroom group setting (Kliman, 1975; Lopez and Kliman, 1979), a therapist works six or more hours per week. During that time the therapist provides psychotherapy individually to each of the five to eight children in the group, each child for fifteen to twenty minutes a day. During each child's in-classroom psychotherapy session a full range of play therapy and analytic techniques are often used, including interpretations of transference, dynamic and genetic interpretations. The interpersonal and educational setting allows a "here and now" focus on resistance to successful socializing and learning. Since sessions occur

almost daily and occur in a real life space, there is little need to delay talking to a child whose attention span might not allow discussion of an event even a few days later.

Two early childhood educators are in charge of the classroom educational activities, which proceed with all the other children throughout any one child's in-classroom psychotherapy session. Teachers and therapist brief each other with the child's help before and after each child's classroom psychotherapy session. The team meets weekly to share communications from parents, as well as to view videotapes and hear the material gathered during treatment that may not have been overheard in the class session.

Parents are interviewed and guided by the teacher each week and by the therapist once a month. Most of the children have existing emotional disturbances, but are also accepted for preventive reasons such as the death of a parent, or placement in foster care. Kliman's, Zelman's and Hope's data (summarized in Kliman, 2006) show considerable rapid emotional growth measured by Children's Global Assessment Scale (DSM IV, Axis V) scores and intellectual growth measured by Wechsler Preschool Scale of Intelligence (revised version) "IQ" scores.

–Excerpted from: Cohen, J. (2013) Chapter 1, In: *Psychodynamic Perspectives on Working with Children, Families, and Schools*, O'Loughlin, M., Ed. (2013), Jason Aronson, Lanham, MD

Alexandra Harrison, MD is an Assistant Clinical Professor of Psychiatry, Harvard Medical School; a Training and Supervising Analyst, Certified Psychoanalyst for Children, Adolescents and Adults, Supervisor, Child Analysis Program, Boston Psychoanalytic Society and Institute. Dr. Harrison has a private practice in Cambridge, Massachusetts and directs the application of Reflective Network Therapy in the Cambridge-Ellis School (Cambridge, Massachusetts). The following essay was written by Dr. Alexandra Harrison for the purpose of introducing Dr. Gilbert Kliman's book: *Reflective Network Therapy in the Preschool Classroom* (Kliman G. 2011).

Reflective Network Therapy In The Preschool Classroom: Introduction

BY ALEXANDRA HARRISON, MD

As a child mental health clinician with more than forty years of experience, I welcome this book on Reflective Network Therapy as an inspiring opportunity to bring cost-effective, theoretically sound, and scientifically tested treatment to a population of children in great need. It makes important contributions to vital fields for parents, teachers, child therapists and finally taxpayers: current new knowledge about brain development and the need for early interventions for children at risk. Kliman vividly and compellingly describes a type of therapy –Reflective Network Therapy– carried out in the classroom by a collaboration of individual therapist, preschool teacher, peers and parents, with seriously disturbed children. The facts that the therapy occurs in multiple short (15-20 minute) sessions a week, and that these sessions are optimally designed to help the children make sense of their otherwise chaotic and frightening worlds “on the spot,” makes it an essentially practical therapeutic modality. Finally, Kliman has done something very unusual in the field of child mental health: he has conducted scientific studies to test the efficacy of the method. In addition to the anecdotal evidence that child mental health practitioners usually put forth to support their methodologies, Kliman has real data to demonstrate its effectiveness, including striking improvement in IQ scores. Thus the method is shown to be a remarkably

“cost-effective” treatment for young children with severe mental health disorders – autistic spectrum disorders, pervasive developmental disorders, trauma, behavior disorders and serious emotional disorders. Kliman does not mention this specifically, but I would add disorganized attachment disorders to the list, in keeping with his in-classroom work with a series of thirty foster children and his series of studies of guided activity workbooks for foster children.

Kliman provides a very practical and helpful introduction to the reader interested in learning more about therapeutic interventions in early childhood – mental health clinician, teacher, or parent. It is comprehensive, including a manual as a guide to practitioners, numerous case examples, and scientific data, in one place. It is also helpful that the book compares the method to other current methods in use today in terms of theoretical foundation, technique, and available scientific data, in a thoughtful and respectful manner.

I have already started using an adaptation of reflective network therapy in treatments of preschool children; two of these children are autistic and one has a disruptive behavior disorder. The method has proved extremely effective. The first child I treated lost her autism diagnosis after less than two years of four times a week therapy. The second two, now in therapy for about nine months, are much improved. All the children were treated by a team including parents, O.T., speech therapist, and teachers. The RNT approach was central to their improvement.

In my treatments, I begin with a videotaped parent consultation evaluation and a recommendation for Reflective Network Therapy. I discuss the method and the conceptual background with both the parents and the teachers. In the classroom, I start each session with a “briefing” by the teacher to me about the child’s day, in the child’s presence. Then I spend approximately 20 minutes playing with my child patient in the classroom or on the playground. We finish with another briefing, this time with me briefing the teacher about the session. I add frequent – sometimes daily – communications with the parents.

My RNT treatments aim to help the child make sense of his or her world through a particular use of play and language. The play is based on psychoanalytic play therapy and attempts to develop the capacity for pretend play and the capacity to make meaning through elaborating potential symbolic themes. The language makes links between inner motivations – cognitive and affective - and behavior, and uses repetition to keep the elements of meaning in awareness long enough to allow the child to attend to them and begin to reflect on them. In this aspect of the method, the presence of others in the child’s environment is critical. The collaboration of peers, teachers, and parents, is a crucial piece of the work.

In my work with these children, I as the therapist make use of the group of peers and the teachers to elaborate a simple narrative linking behavior to inner affective experience. The chance for multiple iterations of the communication, displaced slightly to other listeners than the target child, allows the child the safety to consider the message without having to shut down his emerging reflective capacity. Often, the peers contribute variations of meaning in their own words as part of the growing meaning. Through these experiences in the classroom, OT and speech studies, and play with parents, the child patient is given an enriched developmental opportunity, with the potential for great therapeutic benefit.

Although Kliman (1970), Lopez and Kliman (1975), and Lopez et al. (1996) report some profound child analytic work during the eight month span of a school year in Reflective Network Therapy, it is not a substitute for years of a full scale child analysis. The short duration of the sessions does not easily allow long evolution and

elaboration of symbolic themes. Instead, the analyst prepares a child to think symbolically and teachers can report back on much response to interpretation after the analyst has left the classroom (Kliman 1970 and the Manual chapter of this book). More traditional methods of play therapy or analysis may become appropriate for the same children at later times in their development. Child psychoanalysis (unlike Reflective Network Therapy) though enormously effective and gratifying to provide, can be available to only a few children because of the high cost of four times a week sessions in the analyst's office plus the additional need of parent meetings. As with varying doses of RNT, the most intensive psychoanalytic treatment has been demonstrated to be more effective than less intensive treatments of severely mentally ill children (Fonagy et al. 1999).

Reflective Network Therapy offers the great advantage of high frequency of sessions in combination with an intense involvement in the fabric of the child's relational and educational life, at a fraction of the cost, and without extracting the child from his or her daily routine. I have succeeded in using it in a normal nursery school, where I bring my patients. Especially in terms of the lesser cost and avoiding the requirement that parents bring the child to and from the therapeutic sessions, RNT takes some of the burden off the shoulders of the parents of these children. The design of the treatment is ideal, in my opinion, for scaffolding a young child's development of competencies such as "mentalization," requirements for healthy functioning. In all these ways and for these reasons, Reflective Network Therapy is a significant contribution to the future practice of child psychotherapy and psychoanalysis

–ALEXANDRA HARRISON, MD

JAY S. PARNES, Ed.D. –Dr. Parnes worked closely with Gilbert Kliman as a Senior Administrator for Special Education in the application of Reflective Network Therapy for six years in the San Mateo Unified School District Department of Special Education. Parnes authored the following report as a recommendation of Reflective Network Therapy (then called "Cornerstone") for replication in other special education public school settings.

**Report on the Application of Reflective Network Therapy
Within a Public School Special Education Department**

BY JAY S. PARNES

This is to report that the San Mateo County Office of Education, Special Education programs, has benefited from the services of The Children's Psychological Health Center, specifically its Cornerstone Therapeutic School Project. We have worked together for the past six years. Under the leadership of Gilbert Kliman, M.D., the Center has trained members of our teaching and school psychology staff to carry out a mental health service on our premises. We now have a collaborative project in its sixth year for our special education preschool children with Pervasive Developmental Disorders (PDD) and for those with Serious Emotional Disorders (SED) which interfere with their education. As an alternative to sending children to a private nonpublic special education school for extremely intensive mental health services at significant cost, this project has created and provides just such intensive service within a public preschool special class program at 65 Tower Road, San Mateo.

To my knowledge, among the 30 children served so far under the collaborative project, we are seeing cognitive, social and human gains which have decreased the gap between these children and their typically developing peers. Several families and children are thriving with less intensive special education service or returned to regular education class. Not only has the family and child suffering been reduced, the burden to taxpayers is also reduced. The children have been able to remain in the community, and some who were functioning as severely autistic and retarded now appear to be developing within a somewhat normal range. We are pleased with the quality of special education services our County provides for preschoolers with PDD or SED. We are also gratified with the research results provided by The Children's Psychological Health Center.

We recommend the Cornerstone project to other school systems, so that they consider it an important opportunity should they be able to collaborate similarly with The Children's Psychological Health Center. At California's common cost of \$15,000 to \$40,000 or more a year, for a special education child who needs full time special education services and auxiliary intensive help, the savings for even one child's 12-year career of intensive services in special education can be substantial. The savings from one of the successes we have seen may equal the costs of the entire Cornerstone project with the 30 children helped so far.

We have not yet seen any failures. The agency is showing measurable cognitive gains for our collaborative work which, according to their research, averages 20 to 28 points in independent WPPSI testing of the children in the Cornerstone program. The techniques are far more economical to use than we have found with the Lovaas method, which we also implement for some students. We have also seen the techniques transmitted to special education teachers as well as inexperienced therapists.

-JAY S PARNES, Ed.D.

Senior Administrator, Special Education
December 3, 2001

Alicia Asman Mallo, MD, child psychiatrist and psychoanalyst, served as the Director of Cornerstone Argentina from 2005 to 2010. As she reports below, her fruitful application of Reflective Network Therapy with severely and pervasively cognitively impaired preschoolers was widely reported by her in lectures given to in many scientific societies and hospitals, supplemented by videography, in order to encourage others to replicate this effective method. Positive mental health gains achieved and documented by Dr. Mallo and her team included a rare IQ rise for a very severely retarded autistic child. [See Research Results and Outcome Data] She also conducted a two-year follow-up with a patient who then appeared to be almost completely recovered from autism; she reported on this and discussed how RNT works at a major Psychoanalytic Conference in Santiago, Chile in 2008.

She writes: "Thanks to the application of psychoanalysis and Reflective Network Therapy, we have consistently been able to obtain a positive outcome."

An Application of Psychoanalysis in Preschool Education in Argentina

BY ALICIA MALLO-ASMAN, MD

Psychoanalyst, Infant and Adolescent Psychiatrist, Full Member of the IPA

Since April 2004 I have been managing the Cornerstone Argentina interdisciplinary program along lines designed in the United States by Gilbert Kliman, MD, using the method of Reflective Network Therapy. This experience takes place inside a regular school building in Buenos Aires, Argentina. The Cornerstone Argentina project in Buenos Aires is a model application of psychoanalysis responding to a community need: the treatment of severely disturbed preschoolers by an analytically orchestrated network. The treatment includes a synergistic combination of in-classroom analytic psychotherapy, classroom education, and analytically informed parent guidance and family psychotherapy. Highly disturbed or developmentally delayed preschoolers are generally not adequately treated by education or therapy alone, especially in public educational settings. This project aims to help preschoolers from 2 to 6 years old suffering from severe psychopathologies.

The interventions are based on appropriate psychoanalytically informed knowledge of every child, the group and their families. Our objective is to help the children recognize themselves as individuals within a group and to integrate them into the regular education system. The children from this program join children from other classrooms and share activities such as: cooking, music, self-expression through movement, outdoor play and artistic activities.

The interdisciplinary project requires the intervention of a team that consists of: a head teacher, an assistant teacher, a psychoanalyst, a family psychotherapist and the participations of consultants such as a pediatrician, child neurologist, an educational psychologist, a social worker, a speech therapist and other related specialists. Video-documentation is a regular occurrence. I have been training more than ten Argentine therapists in the method. Argentine newspapers and magazines such as Elle are following the project, which has also received television attention. This type of intervention consists of:

- 1) Psychotherapeutic, educational, and interdisciplinary intervention in a special classroom of a regular nursery school. The intervention is based on the application of the knowledge of psychoanalysis and educational psychology. Individual sessions are held four times a week.
- 2) Gradual child integration within the remaining classrooms, both individually and as a group with an assistant teacher.
- 3) Weekly parent guidance, monthly parent conferences, and family therapy
- 4) Weekly supervision of the team with videotaped material of the children, and interdisciplinary network.
- 5) Consultation with the Medical Director Gilbert Kliman of the Children's Psychological Health centre in San Francisco, USA.
- 6) Making of a life history book for individual children.
- 7) Multi-axial Assessment Scale (CGAS) and educational-psychological follow up with WPPSI and C.A.R.S testing.

Why at school? A human being becomes human together with another human being. The natural course is that a child grows up surrounded by other children. Providing a healthy environment and the exchange with other children turns out to be therapeutic and tend to the integration of the child with himself and with the others. Regarding this issue Freud said, "Spending a good deal of time with other children

clearly forms part of a child's normal development" in Analysis of a Phobia in a Five-year-old Boy. S. Freud. (1909).

Parents play a leading role in this project, participating in parent guidance sessions and family sessions. The whole early intervention method is tailored to the individuality of each child and his family. Most of the children referred have received the diagnosis of Pervasive Developmental Disorders, autistic spectrum disorder, or PDD NOS. These psychiatric categories are described in the Diagnostic and Statistical Manual of Mental Disorders DSM-IV. The diagnoses are characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests and activities.

Ten professionals receiving varying degrees of training in Reflective Network Therapy and two teachers were trained.

I have been delivering lectures about Reflective Network Therapy at several scientific institutions, like the Buenos Aires Psychoanalytical Association, the Argentine Pediatric Society, the Buenos Aires University (Psychology Department), the Argentine Psychiatric Association and several public Hospitals. I also lectured at international scientific events including the International Psychoanalytic Congress in Rio de Janeiro and the Mar del Plata International Psychiatric Congress, both in 2005. I made a film showing follow ups of our patients. With the Reflective Network Therapy team we wrote papers about the development of this method in the culture of Buenos Aires, Argentina. About 450 pages of English publications on Reflective Network Therapy are also being translated into Spanish.

Clinical progress is being documented by CGAS scores and digital video tape recording. Samples of children before and after periods of treatment are available. Several reports have already been made, using such videos and written information to Gilbert Kliman, M.D. The task has been very difficult because the children's disorders are extremely severe. Thanks to the application of psychoanalysis and Reflective Network Therapy, we have consistently been able to obtain a positive outcome. In order to carry out this method properly we found it was very important to work closely and thoughtfully parents as well as with an interdisciplinary team. We supervise the professionals in their classroom and parent guidance work, and confer as a team every week with a deep level of theoretical and clinical discussion.

–ALICIA MALLO-ASMAN, MD

The following remarks by other professionals who have examined the method of Reflective Network Therapy, reviewed the outcome data, and studied videography of individual child patients' psychotherapy sessions conducted in the midst of classroom learning and play activity.

The method is tested by clinical and psychometric studies:

"When I first heard Gil Kliman's presentation on this topic at the joint session of the American College Of Psychoanalysts and the Academy of Psychoanalysis meeting in May 2008 in Washington, D.C., I got goose-bumps. Dr. Kliman has creatively taken the application of classical child analysis a giant leap forward. This method helps developmentally challenged young children develop empathy, relate to family and

peers, and grow intellectually. This method is time tested by clinical, comparative, and controlled clinical and psychometric studies.”

–David Dean Brockman, MD University of Illinois at Chicago, College of Medicine, Medicine Psychiatry, Emeritus; Editor of the American College of Psychoanalysis Newsletter

Daily individualized treatment economically supports cognitive development and emotional health:

“In a small classroom setting, children have the opportunity for testing out much needed socialization skills, which frees them to grow intellectually, while their emotional needs are so richly tended to via their intensive therapy. This, coupled with the support of sensitive teachers and parents who are daily gaining more insight and receiving the support to nurture their children, makes the method an integrated part of each child’s life. It is, indeed, an economical method because children are able to receive daily individualized treatment.”

–Elissa Burién, MA

IQ gains are seen in follow-ups, and behavioral impulsiveness is transformed into words and contemplation:

“I find that Reflective Network Therapy would be applicable in both the public and private preschool settings. It is very helpful that you have very nice follow up on some of the now adults who were preschoolers at the time that you intervened in their lives. The IQ rise that follows upon good treatment of these children by your method is very convincing. It is heartening to see the thoughtful and insightful states of mind developing in children as they feel the impact of the interpretations. I also appreciate the videotaped evidence of this school-based treatment, and how it transforms behavioral impulsiveness into verbalized contemplation. ... I appreciate the meticulous observations that you have recorded and also find it useful that you use a multi-disciplinary team approach, thereby spreading the impact in various disciplines, particularly influencing teachers. It is helpful that you were able to involve the parents intensively and for them to actually be aware of the work as it goes on.”

–Harry Z. Coren, MD, Child and Adolescent Psychiatrist

Children are rapidly engaged. Parents see results and gain understanding:

“I am impressed with how rapidly the children are engaged with the work and how well they respond. The parents are able to see results and better understand both the meaning of the children’s behavior and see the interventions that are used. ... Dr. Kliman has developed a very humanistic approach that these children and their families deserve.”

–Nathan Szajnberg, MD, Clinical Professor of Psychiatry, UCSF, San Francisco Psychoanalytic Institute

The treatment gave profound help to a child with impulsive aggressive behaviors:

“Over the past year I have been privileged to see video tapes of this treatment method used to treat a very disturbed four year old boy. When the treatment started, the child was impulsive, aggressive, disorganized and very difficult to handle. As Dr. Kliman worked with him over the months, his play became less disorganized, and he became able to think more clearly and to verbalize his mental state. This change in the child’s capacities enabled Dr. Kliman to put even more into words for the child, which helped him with the fears and anxieties that drove his aggressive impulsivity. The help to this child and his family was profound.”

–Janis Baeuerlen, MD Assistant Clinical Professor, Adult and Child Psychoanalysis, University of California, Berkeley; Supervisor, Ann Martin Children’s Center; Practice: Child and Adult Psychotherapy and Psychoanalysis

Studying the evidence of actual changes in children:

“After studying parent permitted videotape of Reflective Network Therapy sessions...I wept when I saw videos of actual changes in children, and understood how much good this method was doing.”

–Paul Jay Fink, MD Child and Adolescent Psychiatrist, Clinical Professor of Psychiatry at Temple University School of Medicine; Chair of the American Psychiatric Association’s Task Force on Psychiatric Aspects of Violence, Founder of the Einstein Center for the Study of Violence, et al.

The method has a long history of effective treatment service:

“The Cornerstone Therapeutic Preschool Method [Reflective Network Therapy] has a long history of thoughtful, systematic applications of best knowledge about child development and dynamic theory in establishing a model for early childhood intervention that has primary and secondary preventive effects. It brings together, in a most sensible way, childhood educational and therapeutic synergistic service to preschoolers and individualized assessment and treatment as indicated. For many years it has been an outstanding example of how best knowledge can transcend racial, ethnic, and financial challenges. Therefore, it is a most useful in both public and private preschool settings. I am delighted to recommend The Cornerstone Method Therapeutic Preschool Method [Reflective Network Therapy] enthusiastically.

–Albert J. Solnit, MD Sterling Professor Emeritus and Senior Research Scientist at the Child Study Center at Yale University School of Medicine (1952-1990), Professor of Child Psychiatry, Pediatrics and Psychiatry; Managing Editor of The Psychoanalytic Study of the Child for 20 years; Elected to the Institute of Medicine of the National Academy of Sciences (1980); Commissioner of the Connecticut State Department of Mental Health and Addiction Services from 1991-2000.

**TRAINING AND CERTIFICATION
IN REFLECTIVE NETWORK THERAPY**

Basic Information for Psychotherapists, Educators,
School Administrators and Graduate Students

Presentations about Reflective Network Therapy: Dr. Kliman frequently makes presentations at mental health, educational and scientific meetings, conferences, seminars and workshops; contact Gilbert Kliman, MD to schedule a presentation: 415 292-7119. Public and private schools serving special needs preschool children, which are ready to assemble staff and decision makers to explore replicating the method with the children they serve, will be given priority in Dr. Kliman’s schedule.

Fast track for Senior Therapist Certification:

Contact us for information about expediting establishing RNT service in a site where your current pupil-patient population is waiting to be served. Our agency maintains a

high quality video conferencing facility. Skype can be used for training. If you have high quality videoconference capability at your end, we can share actual treatment sessions and discuss treatment techniques by interactive video in real time.

Distance Learning: Training in Reflective Network Therapy using high quality video conferencing is available for university courses and seminars, mental health agencies and private practitioners. Training in preschool therapy techniques for autistic children, traumatized children, homeless or recently homeless children is available. Consultation and training in psychological first aid for children and families stricken by disasters is also available.

On-site Training for Private and Public Special Needs Preschools

CPHC provides onsite training, guidance and supervision for mental health professionals; including psychiatrists, psychotherapists, psychologists, social workers, MFTs and teachers; to obtain Certification. Training for certification in the method includes on-site training, distance learning, seminars, presentations, and training DVDs as well as the use of other materials for study. Graduate students can find thesis opportunities with CPHC.

Teacher Training is conducted by CPHC certified senior staff. The training uses The Reflective Network Therapy Manual; selected readings; and videotapes of briefings, debriefings, and full therapy sessions with individual children in the classroom, which illustrate dynamic techniques, children's immediate responses, therapeutic turning points, and long term changes. Additional training is provided by video conferencing. Therapists learn: to attune and focus on a child's interpersonal relationships and communication of here and now play, behavioral and emotional process, and to help the child mentalize that process; to provide clinical leadership of the classroom team; basic concepts, processes and procedures of Reflective Network Therapy.

Senior therapists certified by The Children's Psychological Health Center lead a start-up weekend of training. On the third day, demonstrations are given with actual children in the real-life setting of the new site. A site's teacher is chosen to help do briefings and debriefings, and one of the training therapists does a demonstration with several children for a morning. Discussion is held in the afternoon, based on videotapes of the morning's work. The therapist supports and guides teachers to develop or deepen skills, achieve performance expectations and learn method techniques both explicitly and through modeling. Briefings and debriefings and working in tandem in the classroom provide opportunities for teacher training as do the weekly staff meetings.

Ten videotaped sessions of the senior clinician's own Reflective Network Therapy work is reviewed by an RNT-trained therapist as part of personal supervision. That supervisor certifies whether the work is inclusive of and demonstrates reliable use of the basic techniques of Reflective Network Therapy, including successful use of interpretations and collaborative inclusion of material from teacher briefings. Some supervisory sessions may be facilitated by videoconferencing. Teachers aiming at certification will provide videotapes of their work to their CPHC trainer for review, discussion and guidance. In-classroom video documentation is made at least weekly.

Teacher Certification in Reflective Network Therapy:

Head teachers must be licensed in their state or supervised by a state licensed teacher, and must have training appropriate to the age levels of their pupils. Special Education Certification is desirable for the head teacher. Teachers will study actual treatments by viewing RNT training DVDs and participate in discussion facilitated by

the CPHC certified trainer or supervisor. These DVDs demonstrate many aspects of technique essential for carrying out the method. A Teacher must complete at least one semester of supervised practice in an RNT classroom with at least five children, two reaching a planned termination, at least one of the children being female, and at least one child with an autism spectrum disorder or a serious social communication disorder.

Mid-Level or Junior Psychotherapists: Psychotherapists who lack certification in psychoanalysis but have had sufficient relevant experience are often very effective in Reflective Network Therapy. Depending on prior levels of training, the junior and mid-level therapists will require more initial supervision than senior therapists such as analysts and Board Certified Child psychiatrists. Ideally they will receive at least 20 rather than ten supervised hours.

Certified Therapists will regularly provide their RNT supervisors with standardized reports which capture data on child patients.

Opportunities for Graduate Students:

Candidates for voluntary research study include trainees in child psychiatry and psychology and preschool education services. Contact us about our current research projects, thesis opportunities and internship possibilities.

DVDs for Education and Training:

Our instructional DVDs are videotapes of our work during actual in-classroom Reflective Network Therapy sessions. The DVDs are also permitted for scientific research. This valuable archive of briefings, debriefings, and full therapy sessions with individual children in the classroom illustrates uses of a spectrum of dynamic techniques, children's immediate responses, therapeutic turning points, and long term changes. Hundreds of cross-sectional and longitudinal studies (studies that follow the same child, over time) of emotionally and cognitively-growing RNT-treated children comprise an archive that scholars, teachers, and therapists have parental permission to study. DVDs are selectively made available only to credentialed mental health professionals, qualified educators, supervised interns and qualified advanced students in the mental health field. There is no charge for these DVDs; they are not for sale. They must not be copied or viewed by other persons. A CPHC Confidentiality Agreement to protect the identity of child patients is required.

**Download Confidentiality Agreements
and read more about training and certification on our website:
www.childrenspsychological.org**

Kliman Diagnostic and Therapeutic Preschool Service

Notice of Privacy Practices (NPP) For Protected Health Information

This notice describes the privacy practices of Kliman Diagnostic and Therapeutic Preschool Service, including how we may properly use Protected Health Information. This notice also describes your rights as well as actions you may choose to take to help ensure your child's privacy.

How Kliman Diagnostic and Therapeutic Preschool Service may use and disclose your child's Protected Health Information we collect at the beginning treatment and discover during the course of treatment:

With permission from the parent or legal guardian, we obtain and study your child's medical records, mental health records and school records. That is protected information. When a child is registered for our services, the parent or guardian provides a great deal of personal and confidential information about the child and the family. That is protected information. It is our practice to use all we learn about the child for the child's benefit. In the natural course of treatment, some of the child's Protected Health Information is necessarily disclosed in accordance with federal and state regulations. Selective disclosures are made in order to advance treatment:

- **Disclosures are made to parents and to others with the parents' written permission.**
- **Disclosures are made to members of the treatment team.**
- **Disclosures necessary for the child's care may be made to those directly involved in the child's care.**
- **Disclosures may be made for follow-up testing, assessments or evaluations.**
- **Disclosures may be made during a consultation with a prior or current mental health professional.**
- **Service disclosures which include protected information are made to insurance companies, Medi-Cal and other parties financially responsible for payment.**

We may also use your child's treatment and outcome data without making any disclosures of any kind for purposes of treatment study, clinical research, education or training. No names and no Protected Information which could identify a child are ever included in work done for these purposes.

SPECIAL SITUATIONS

How we may use and disclose Protected Information without your consent, authorization or opportunity to agree or object verbally:

As Required By Law: We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

To Avert Serious Threat to Health or Safety: We may use and disclose Protected Health Information when necessary to prevent a serious threat to your child's health and safety, the health and safety of another person, or the health and safety of the public. In

doing so, we would only disclose such information to parties able to help prevent the threat.

To Accomplish Support Tasks: We may use a company or support staff for billing, transcription, or consultation that would require access to Protected Health Information to perform services. Any such company or person or professional would be bound by a Confidentiality Agreement.

Abuse, Neglect, and Domestic Violence: We may disclose private Information to the appropriate authority if, based on our professional judgment, we believe a patient is the victim of abuse, neglect, or domestic violence. We will only make this disclosure when it is required by law or when a parent or guardian agrees to such disclosure.

Data Breach Notifications: We may disclose Protected Health Information to provide legally required notices of unauthorized access or disclosure of your Protected Health Information.

For Lawsuits and Disputes: We may disclose Protected Health Information in response to a court order, a subpoena, discovery request, or other legal process. Protected Health Information will only be released after efforts have been made to inform you of the request and an order protecting the information has been given. We are also permitted to disclose Protected Health Information to defend ourselves in the event of a lawsuit.

Coroners, Medical Examiners, and Funeral Directors: We may release Protected Health Information to coroners, medical examiners, and funeral directors so that they can carry out their duties.

Other uses of Protected Health Information not covered in this notice or under laws that apply to us will be made only with your written authorization: If you provide us with your written authorization to use or disclose Protected Health Information, you may revoke that authorization at any time in writing. If you revoke your authorization, we will no longer disclose Protected Health Information permitted by that authorization, but the revocation will not apply to disclosures previously made with your permission.

OUR RESPONSIBILITIES

Kliman Therapeutic Preschool Service is required by law to: Maintain the privacy of Protected Health Information; provide you with this notice of our legal duties and privacy practices with respect to Protected Health Information; and abide by the terms in the notice currently in effect. We are also required provide you with written or other notification in accordance with federal and state law if we discover a breach of unsecured Protected Health Information. In almost five decades of treating more than 1700 children in this country and in other countries, using treatment teams trained and supervised by Kliman Diagnostic and Therapeutic Preschool Service director, Gilbert Kliman, MD, no such breach has ever occurred.

All Kliman Diagnostic and Therapeutic Preschool Service treatment team members are fully trained in our privacy practices, including using systems and taking measures to safeguard written and electronic records and communications containing Protected Health Information.

KNOW YOUR RIGHTS:

The Right to Request Restrictions: You have the right to ask us not to disclose any part of your child's Protected Information with certain family members or friends. If you do not want any Protected Information shared with family members who are safely interacting with your child regularly, your request should state the reason for their exclusion. We may want to discuss this with you if your request includes family members who are an important part of your child's support system, as they may benefit from having some Protected Information.

We are not required to agree to a restriction you may request. For example, if your Health Care Provider believes it is in your child's best interest to permit use and disclosure of your Protected Health Information, your child's Protected Health Information will not be restricted. If Kliman Diagnostic and Therapeutic Preschool Service agrees to any restriction you request, we will not use or disclose your child's Protected Information unless that information is needed to provide emergency treatment.

Right to Ask that Confidential Communications are made in The Way that Works for You: You may ask Kliman Diagnostic and Therapeutic Preschool Service staff to contact and communicate with you only in certain ways to preserve your privacy. For example, you may prefer that we communicate with you only by phone or, if the matter can wait, by mail. You may not want us to call you at your workplace unless there is an emergency. We are happy to agree to any workable request to communicate with you in a certain way. You may request for us to communicate certain information with you via email messages.

Right to Summary and Explanation: At Kliman Diagnostic and Therapeutic Preschool Service, the treating professional will meet with you monthly to provide a timely progress summary and gather your valuable input and insights as we work together on your child's behalf. You have the right to request a written summary of your child's Protected Health Information from our records at reasonable intervals, which is likely to be more useful to you than a copy of the entire record.

Right to Know about Disclosures of Protected Information: Technically you may ask for an "accounting of disclosures" at no charge, but this right does not apply to the usual purposes for which Kliman Diagnostic and Therapeutic Preschool Service makes disclosures: disclosures for treatment or payment; disclosures made to you or made with your written permission; and, disclosures to those directly involved in your child's care and treatment.

Right to Security Concerning Your Genetic Information: You have the right to be assured that your child's personal Protected Health Information, as defined as Genetic Information in certain cases, not be used or disclosed to health plans for underwriting purposes.

Right to Request Non-Disclosure of Out-of-Pocket Payments to Your Health Plan: If you make a payment on time or before receiving services from Kliman Therapeutic Network Services, you have may ask that your Protected Health Information with respect to service is not disclosed to your Health Plan. We will honor your request as long as financial obligations are met.

Right to an Electronic Copy of Electronic Medical Records: If your child's Protected Health Information maintained by us is in electronic format, you have the right to request a copy of that information to be given to you or transmitted to another individual or agency in electronic form.

Right to Request Amendments: Kliman Diagnostic and Therapeutic Preschool Service cannot change records created by other providers. However, if you believe that there is

something significant in your child's cumulative Protected Health Information is wrong, we would appreciate knowing about it. You may ask us to amend a record created by us, kept by us and for our records, which you believe contains an error. A request for amendment must be made in writing. If we agree, we will make the change; if we believe that there is error in our records, we will talk with you about it before we deny any such request.

Right to Inspect and Copy: You have the right of access to inspect and copy your child's Protected Health Information that may be used to make decisions regarding your treatment and plan of care. There may be a charge for the costs of copying and resources. In some instances, if we feel there is a good reason, we may not include psychotherapy notes. If that happens, you have the right to appeal the denial of that part of your child's records maintained by us and have our decision reviewed by a licensed healthcare professional not directly related to the denial.

Right to Opt Out of Fundraising Communications

Right to Paper Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time, even if you received this notice electronically.

To exercise any of your rights described in this notice, please make a request in writing.

PRIVACY COMPLAINTS

If you believe your child's privacy or your privacy or any of your rights as described in this notice have been violated, you may file a complaint with Kliman Diagnostic and Therapeutic Preschool Service and/or with the U.S. Department of Health and Human Services Office for Civil Rights. To file a complaint with the U.S. Department of Health and Human Services, you may call 1-877-696-6775 or visit the website of the Office of Civil Rights at: www.hhs.gov/ocr/privacy.

You will not be retaliated against for filing a complaint.

Kliman Diagnostic and Therapeutic Preschool Service may not threaten, intimidate, coerce, harass, discriminate against, or take any other retaliatory action against you or any other person for filing a complaint.

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–for children, parents, teachers, case workers, first responders and relief agencies

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- ❖ **A workbook for Homeless and Recently Homeless children**
- ❖ **Workbooks for children traumatized by terrorist attacks or by living in conditions of regional conflict or war.**

Disaster Relief Agencies may obtain licenses for mass distribution.

Kliman Diagnostic and Therapeutic Preschool Service
Children's Psychological Health Center, Inc.
at The Kiwi Preschool
573 Summerfield Ave., Santa Rosa, CA

To learn more, please explore our website
www.childrenspsychological.org



To reach Gilbert Kliman, MD
Call 415 292 7119 or 707 978 2755