REFLECTIVE NETWORK THERAPY:

HOW-TO-DO-IT MANUAL FOR THERAPISTS, TEACHERS AND PARENTS

Gilbert Kliman, MD and Elissa Burian, MA

Introduction

This manual may be used as a stand-alone practical guide for use in training. By creating a how-to-do-it manual, we hope to encourage and increase the systematic replication of Reflective Network Therapy (RNT) and augment the comparability of work and research done at multiple sites-sites. Only when a team follows a manual can we compare the results of sites using therapeutic apples with the results of other sites using hopefully the same therapeutic apples. The manual details the method's procedures, including reflective classroom techniques to help children see both themselves and others as full people. It presents concrete guidelines for helping children to heal their troubled emotions and developmental disorders using Reflective Network Therapy. Therapeutic concepts and processes are incorporated into the manual through real life examples of children's treatment. A series of excerpts from clinical and scientific papers about the method (included later in this book) supplements the manual. They are an adjunct for advanced training, with rich information about how the method has been used.

In most psychoanalytic therapies for preschoolers, children are pulled out of their classrooms into a private office with one person, a therapist (or therapist and parent) or work with a one-on-one behavioral aide. In contrast to a standard child analysis, DIR/Floortime psychotherapy or the Lovaas Method (ABA), a child treated with Reflective Network Therapy is never pulled out of the classroom. Instead, a whole network of attached and attuned helpers works with the child in a classroom group. Rather than having a two person interaction with an aide or therapist, the child learns to value and share the RNT therapist with peers. The RNT therapist deliberately works with others individually in the child's presence, increasing the value of therapy to all of the children and stimulating a healthy desire for therapeutic time. There is identification of each child with each other child's socially discussed mental life and therapeutic process. A child in a Reflective Network Therapy classroom is always in a peer-inclusive process, which is therapeutically valuable as well as responsive to the philosophy and legal concerns of modern public special education.

We don't know yet how old a child can be and still benefit. Given outcome data showing that the method rapidly and usually produces IQ rises among testable children, and considering neurologic research suggesting more brain plasticity than previously thought, we suspect that particularly anxious, traumatized and many developmentally delayed children could benefit from this method at any point in childhood. It remains to be seen whether RNT is dependent on a narrow time window as a factor allowing substantial brain plasticity and growth. We believe the treatment produces positive effects on IQ through neuronal growth and connections. We know that neuronal growth is also stimulated in some animals by certain medications, (Lagace, Noonan and Eisch, 2007). Whether any interpersonal treatment can produce detectible brain changes is under consideration for more formal study even as we write. Stanford's Department of Psychiatry has a related project, hoping to determine whether individual autistic and other genetically compromised children's brains vary over time (Carrion, Weems and Reiss, (2007; Hoeft et al., 2010).

The Children's Psychological Health Center, Inc. provides Reflective Network Therapy training for professionals who treat preschool-age children within mental health clinics, and public preschool special education services. We give ongoing supervision with priority to nonprofit, governmentally assisted and potentially stable projects in well-established agencies. [See appendices A and B in Reflective Network Therapy In The Preschool Classroom, Kliman, 2010]

Therapists need more start-up training help than parents or teachers with this method as detailed below. A professional child therapist who is new to the method needs several full days of initial training before starting, followed by weekly supervision for a year. Some teachers have succeeded in start-up just by using videotapes for training. As they progress, their own videotaped therapy sessions can assist the team and the supervisor in assuring quality control. Weekly conferences which include viewing and discussing videotapes of recent RNT psychotherapy sessions increasingly enable the team to monitor itself after a few months. When establishing a brand new service site, it is important to set up a systematic data collection system for measurable outcome data before starting treatment and to re-asses that system after several months of operating the new program to verify that the data collection method is working. In many communities a school psychologist could do the initial and follow up IQ testing and CGAS scoring on children in RNT classrooms.

Parents and teachers do not need prior specialized knowledge or experience with Reflective Network Therapy to participate. Inexperienced preschool teachers and day care workers, and even therapists with little prior experience in other forms of therapeutic education or special education have all successfully used the RNT method, often with very difficult children. Because RNT procedures are quite natural, many families and educators can create Reflective Network Therapy services or use the method with a particular child within their private preschools and public special education classes. For four decades, the method has helped keep troubled children in their schools and communities, helping them learn to relate lovingly to their families and socialize well with their peers. The method has generally been used with modest cost and high effectiveness. It has served as a social and educational bridge for hundreds of children, allowing most RNT graduates to continue mostly in regular elementary education classrooms in regular schools, and go on to become engaged, contributing members of their families and communities.

Many parents and therapists ask about medication and other supplemental treatments, such as nutritional therapy, speech therapy, and applied behavioral treatments for child patients. Concerns about medications are particularly important for the senior author as a medical doctor and psychiatrist working with very young children whose bodies and brains are developmentally evolving and are much more vulnerable to some side-effects than are adults. My team members and I are comfortable with psychotropic medication prescribed by pediatricians, so long as use is being monitored for side effects and general safety. RNT teams and I have recommended medication for only a very few of the 1500 RNT children treated so far. On the contrary, we are likely to recommend reducing or removing medications as children improve within the benevolent influence of their therapeutic human network. Children should continue any prescribed medication(s) when they first enter treatment. We prefer that children do not start new medications soon after starting RNT. We urge at least a trial of RNT before medication is changed.

It takes two or three months in the Reflective Network Therapy classroom to establish a baseline of observations which might support a recommendation to the child's pediatrician for the reduction or elimination of medication(s). Zelman's studies (1996) show that the worst IQ outcomes among his twice-tested cases were among children treated by another method who were also medicated. They actually declined in IQ, contrasting sharply with unmedicated RNT-treated children who experienced rises in IQ.

None of our 69 twice-tested IQ series) continued with ongoing Applied Behavioral Analysis (Lovaas method) treatment while in RNT. No child who started RNT treatment with an ABA aide has ever needed the aide in the Reflective Network Therapy classroom after a week or two. We do encourage continuing any dietary, speech therapy, occupational therapy or other appropriate treatments already in progress when children enter our program. We are particularly eager for autistic children to have speech therapy, which we prefer to go on right in our classroom.

Comparing Reflective Network Therapy with Other Interpersonal Therapies

So far, it appears that Reflective Network Therapy is the only psychotherapy method which reliably and regularly produces IQ gains as well as mental health gains among over 95% of its IQ testable patients. Individual psychodynamic psychotherapy and individual child psychoanalysis have not studied

IQ outcomes very much and do not regularly produce IQ gains (Kliman, Schaeffer, Friedman and Pasquariell, 1982; Zelman, 1996). Theraapeutic preschools which are psychoanalytically informed but function without an in-classroom therapist (Furman & Katan, 1969) have never reported such regularly occurring gains. We can't rule out that possibility until a few such schools have become psychometric data collectors, including initial and later IQ testing. When considering other interpersonal methods, which are particularly appropriate for comparison to RNT, we think often of Mahler's tripartite therapy (Mahler, 1968) which encouraged a parent, child and therapist to engage as a reflective team. RNT develops this aspect further. Some features and goals of later-developed two-person methods such as DIR/Floortime are identical with those of RNT, particularly the emphasis on promoting empathy and attunement with a caring, affectionate adult. Publications of our methods preceded Stanley Greenspan's valuable work (Greenspan, 1992) by decades. RNT psychotherapy sessions are the same length as later adopted by DIR/Floortime: fifteen to twenty minutes. The involvement of parents is absolutely central to both methods. With DIR/Floortime, educators are not used synergistically in the classroom (as they are in RNT treatment) but they certainly could be. DIR/Floortime used for multiple years with a responsive child has outcomes with resemblance to RNT's outcomes after eight months. A subgroup of 16 DIR/Floortime treated autistic patients was followed for ten years, selected because of their promising early response to that method. They did very well academically and socially, despite the ominous diagnosis received years earlier (Greenspan and Weider, 2005).

Almost all testable RNT treated children have IQ rises, averaging 12 to 28 Full Scale IQ points after 8 months of treatment. Greenspan reports that 20% of autistic preschoolers who are testable and treated have IQ gains with DIR/Floortime treatment. But this treatment requires *two to five hours per day for 2 to 8 years* to achieve such gains. A key technique difference between RNT and Greenspan's method is that DIR is characteristically limited to influencing mother-child couples which is close to a one-on-one approach. In sharp contrast, making it appropriate as a school-based method, Reflective Network Therapy always uses the classroom network with multiple peers. RNT emphasizes systematic ways of multiple helping participants adding reflections, creating a social hall of peers with adult mirrors adding multiple caring attunements.

RNT systematically includes and depends on early childhood classroom education, classroom social processes and at the same time makes daily use of child analytic techniques. For those many children who can discuss or listen to a discussion of their own behavior even in the most limited way, we consistently use interpretive psychotherapy in the midst of real-life play and real-life interpersonal interaction within the classroom. A full range of dynamic and "defense-focused" interpretations are often appropriate to the growing abilities of a child. Defense-focused interpretations particularly concern a child's resistances to being taught and loved by the adults and peers. Sometimes it is possible to get a child to understand he is deeply fearful and defensive about intimacies such as receiving information and that he actually dreads the opportunity to learn new skills. When this information becomes conscious, such defenses can be significantly mitigated. Our work is unlike therapeutic nurseries run by teachers (Rosenblitt, 2005) which by design avoid the actual psychoanalytic process of making interpretations. The RNT method regularly uses in-the-classroom interpretations of in-school behavior to help children overcome arrests in development. The in-classroom therapist can often help a child understand connections between past and present and make connections between transference processes in school, which come from experiences with persons in the child's family life.

See Chapter 9 of Reflective Network Therapy in the Preschool Classroom (Kliman, 2010) for detailed comparisons of Reflective Network Therapy, DIR/Floortime, ABA, TEACCH and individual "pull-out" psychotherapy in terms of clinical results, versatility, feasibility, replicability, cost benefits and time required for improvements.

Replication Techniques, Processes, Procedures and Classroom Structure

Reflective Network Therapy is helpful for most seriously emotionally disordered (SED) preschoolers. The method is also appropriate and evidence-based for young children with pervasive developmental disorders (PDD) including autism (often referred to as autism spectrum disorders or ASD).

Like any psychotherapy, the method is tailor-made for each patient. Thus it also helps children with some psychiatric diagnoses that do not neatly fit into broad categories. Reflective Network Therapy's spectrum of utility and its capacity to be tailored to an individual child's needs makes it effective for children with anxiety disorders, oppositionalism or attentional and hyperactive difficulties.

Normal children (children with no psychiatric diagnoses or severe disorders) including staff members' children as well as healthy preschool siblings of preschoolers with serious disorders have sometimes attended RNT classrooms. They have helped other children, grown in altruism and enjoyed their "expert player" status. Some of these children have received scholarships to attend, making the classroom population more diverse. Parents report that these children benefited from attending, though we have no systematic data about them yet.

There is very strong statistical evidence of the method's value for foster children (Kliman, 2006). It is no coincidence that the first Cornerstone therapeutic preschool where Reflective Network Therapy was applied was originally established as part of The Center for Preventive Psychiatry, to preventively help traumatized and orphaned children (Kliman, 1968). Our experience with the method leads us beyond treatment, to encourage preventive referral of bereaved children and foster children even if they presently have no diagnosable disorder.

Settings:

This method works well as an enhancement to an ongoing special education service. It can also be a separate classroom service in a public school. Reflective Network Therapy works well in a part-day or full-day preschool, daycare service and in preschool programs in community based mental health facilities. The method also does well in an independent part or full time preschool. Inclusion of Reflective Network Therapy service for children into a larger public school special education class, Head Start, daycare center or similar agency is valuable for the purpose of achieving full mainstreaming of many of the children in one or two years. Inclusion in a larger public school is a means for encouraging social growth of the child patients within the larger community. It helps de-stigmatize the psychiatric problems of young patients. Ideally, in such comprehensive settings, the method can be offered as an enrichment or supplementary service, scheduled like a music class or physical education activity during part of every school day.

Frequent classroom sessions (five times a week for several hours each) work reliably and even better, as our outcome data shows. At a minimum, two or three in-classroom educational sessions at least two hours long are required each week, with psychotherapy occurring in the classroom each of the days for each child. The children served can also join in playground activities and classes with other children in the same school during part of the rest of the day with at least a teacher's assistant who is learning or is trained in Reflective Network Therapy close by. Cornerstone Argentina is using this mixed class model, having the children join with other classes during recesses, outdoor activities, and art classes. The tightly integrated peer functioning of the RNT therapeutic classroom participants as a network promotes a deep inclusiveness in the classroom group, in contrast to having an aide or other therapist always at the child's side. RNT nurtures nonverbal as well as verbal children and leads them to relate to each other and their families, to trust and love their teachers, to play and learn with other children and parents and become ready for fuller future mainstreaming. Most of our children go on to regular education in public schools by first grade.

Reflective Network Therapy is an inclusive method, deliberately treating children within their classrooms rather than pulling them out of class for behavioral modification or individual psychotherapy. RNT does not segregate or isolate children socially from inclusion within the therapeutic classroom group by having an adult aide constantly at a child's side. RNT treatment and education gives a child a gradual transitional preparation for entry and inclusion into the larger real world. It cushions children, protecting and limiting their actions and serves as a stimulating but protective half-way house en route to the more demanding larger community. It is a "holding environment" (Winnicott, 1965) giving children opportunities for soothing, impulse-containment and expression-supporting relationships, thus not only allowing growth

but also correcting for developmental and behavioral difficulties, (Alpert, 1941, 1954; Alpert & Rapin, 1953). Children are contained by the thoughtful, understanding presence of teachers and a therapist who understand each child's developmental status, needs and individual impulse control limitations, and who encourage the evolution of his or her expressive skills.

This method differs from other psychotherapies and educational approaches in several ways. It is unique in the way it deliberately combines classroom education with interpersonal psychotherapy. Since children are not removed from the classroom, psychotherapy sessions are witnessed, shared and reflected on in the real life space of the classroom by all of the teachers and children in the group. Thus, Reflective Network Therapy makes therapeutic use of all the material and behavior which arises naturally in this setting.

The psychotherapy aspects of this method are based on interpersonal rather than behavioral conditioning influences. A complex network of interactive helpers (peers, therapist, teachers, teachers' aides and parents) works with the children as a team, supported by the principles and practices inherent in Reflective Network Therapy. In a reflective network, information (about behavior, expressed fantasies, perceived feelings, significant events and therapeutic themes) is all communicated openly among all adult and child persons in the classroom as well as shared directly with the index child. Thus, each child patient as well as adult helpers witness the index child through a set of social lenses and can access mirrors of others' views and feelings. Each child patient can come to perceive him or herself as richly understood in an empathic fashion by teachers, parents and therapist, and importantly, by other children.

Until now, there has been no systematic, replicable and inclusive method of deliberately applying individual interpersonal psychoanalytic therapy entirely within a preschool educational setting. Rather, children have been grouped for educational work and individuals have usually been removed from the classroom or even transported elsewhere for what psychotherapy the school believes is necessary. RNT has been successful in many settings: preschools, day care, homeless shelters, special education classes, and Head Start settings with children having multiple psychiatric diagnoses including pervasive developmental disorders and posttraumatic stress disorders.

The need for an in-classroom method of school-based psychotherapy literally combined with education is great. The purpose of this manual is to create a basis for carrying out such therapy in school classroom settings, using Reflective Network Therapy. This manual is data and theory driven. It selects features related to the way data has shaped how the author thinks of the method. It describes the techniques and procedures required to achieve the cognitive and clinical gains Reflective Network Therapy induces.

Reflective Network Therapy is distinctive in its cognitive and clinical gains combined. Other methods rarely produce combinations of the large clinical and IQ gains seen with RNT. One reason may be that other methods lack targeting of both emotional and cognitive achievements. Most lack simultaneous interdisciplinary aims and most lack real-life environment as an arena for therapy. The synergy between disciplines of teaching and therapy creates an emotionally and cognitively powerful reflective network in the classroom, which supports and nurtures, mentally enriches, and stimulates children's emotional and cognitive growth simultaneously−each discipline including and magnifying the effects of the other.

The multigenerational human network set up in RNT includes familiar but newly reinforced care-givers (parents), care-giving teachers and peers and is optimal for the purposes of meeting many treatment needs. Treatment using this method can open the child to receive nurturing, and at the same time to begin thinking about himself and others as a result of receiving multiple sources of reflection from others in the reflective network. Once the child begins to be able to think about himself and his feelings, he simultaneously begins to build a repertoire of how to think about and relate to others, developing both his empathic capacity and his communicative repertoire. The deliberate therapeutic and educational use of multiple human beings in the classroom allows for the modeling of thoughtful and affectionate interaction. Therefore, the method's technical emphasis is on verbalized emotions and thoughts--the

mentalized forms of behavior (Fonagy & Target, 2003). The child's expressive behavior and perceived emotional states are reflected back to him or her semantically, with love, discipline and transmission of various forms of cognitive and insightful knowledge.

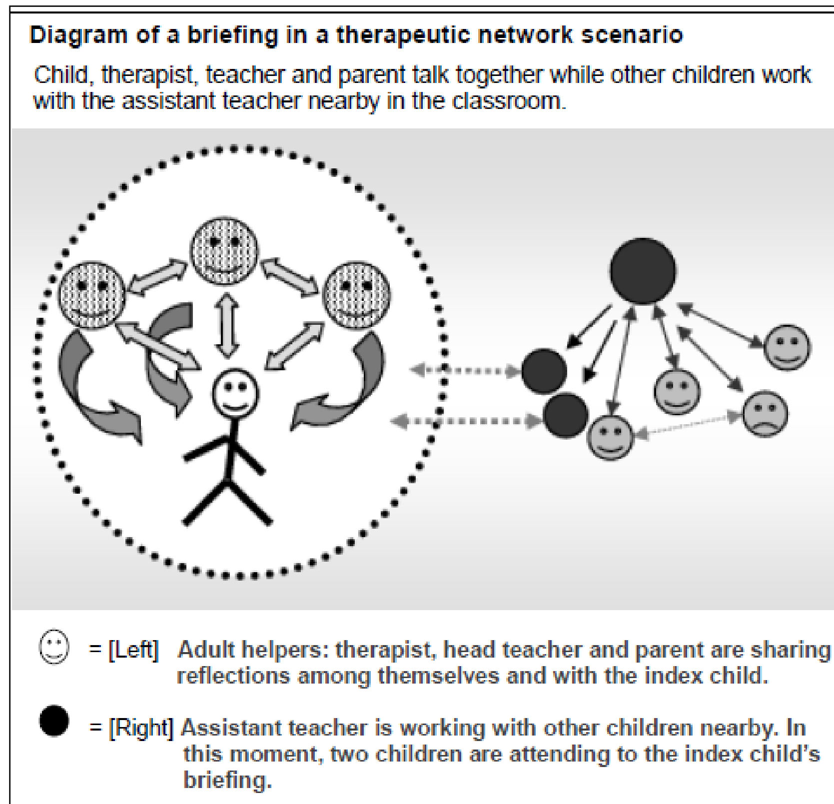

Figure 3.1 Diagram of a therapeutic network scenario

The development of thinking itself depends on interpersonal practice, as Fonagy profoundly expresses, in his presentation of the concept of "mentalizing" (Fonagy, 2000; Fonagy et al., 2002). Fonagy defines reflective function or mentalizing as the capacity to think about mental states in one's self and in others. He suggests that the capacity for reflective awareness occurs originally in the caregiver-infant dyad. The baby's relationship with the mind of a caregiver increases the likelihood of the child's secure attachment, which, in turn, facilitates the development of mentalizing in the child. Fonagy proposes that a secure attachment relationship offers an immature mind a chance to explore the mind of the caregiver, and in this way to learn about minds.

In this interpersonal and intersubjective model, the development of a self-concept could be rendered as a variant of Renee Descartes' "I think, therefore I am." The child's self-concept is dependent on a mutually regulated awareness of information and emotions experienced during relationships. Long before a child is a preschooler, he usually begins to experience complex reflections of how others feel about him and how they think of him. A child has concepts such as: "My caregivers have feelings about me and I have feelings about them. They have thoughts about me. I have thoughts about them. They think of me. They know I am thinking. I am living as a thinker." Fonagy (2000) argues persuasively that the therapeutic effect of psychoanalysis depends on its capacity to activate patients' ability to evolve an awareness of mental states and thus to find meaning in their own and other people's behavior.

Theory is important. But this how-to-do-it manual about Reflective Network Therapy is intended to go beyond theory, to give teachers and therapists a practical structure and specific guidelines for

establishing a reflective network of treatment influences in their own RNT service. It will also be valuable for parents who wish to participate with professionals, joining them in a systematic collaboration to help their children using RNT. In addition to theory, data about clinical and cognitive improvements inspired and guided the manualization of the method.

Classroom Climate

In the classroom, we consciously develop, employ and strive to maintain a loving attitude and loving feelings for each child-patient, in each and every circumstance. We recognize the therapeutic functions of appropriate love as an essential therapeutic element and consciously cultivate it as a subtle but reliable, background emotional climate. Negative feelings which might arise within any of the adult participants in the therapeutic network are deliberately and openly acknowledged and worked through in structured interactions. These include weekly parent guidance sessions and staff meetings. The staff meetings include review of recent videotapes of the work, mutual supervision, with leadership by the classroom psychotherapist.

Angry or sociopathic teachers and therapists must be excluded from this work, during the hiring process. Excellent references are a great help in screening for talent rather than trouble. We've been fortunate in having been free of such limitations and difficulties within staff. Excessive fastidiousness and rigidity is another handicap we have not experienced with our staff. Team members should be empathic, receptive, flexible, imaginative, creative, and able to tolerate children's regressions and aggressions, as well as their tenderness. They need tolerance for their own positive and negative countertransferences. They need a rich ability to feel love for the children and parents, and to accept parents unconditionally without tolerating child abuse. They need to be able to cultivate the best in classroom colleagues and to accept as food for thought the observations of collaborating educators and therapists. To some extent, they have to able to learn to appropriately care about and love each other. It helps to be able to be playfully childlike in the classroom at times, without regressing in reality testing and impulse control.

In the interest of stability and minimizing influences extraneous to the natural classroom composition, visitors should be few. Observation for training is best done through video or one way mirror. More than one therapist in the classroom may be confusing. Lopez, Balter and Howard (1996) have reported successful use of multiple therapists with no teachers, but we have not been able to observe enough to confirm the finding nor do we have outcome data yet on that effort.

Standards and Structure

There is a range between ideal and well-tested or maximal standards and minimum standards. The maximal standards are very highly likely to produce cognitive and clinical gains. The minimum standards are less likely to be fully effective but are likely to be at least clinically positive and useful when practicing Reflective Network Therapy. Deliberately being repetitive, we will emphasize throughout the manual that some guidelines and aspects are considered essential, such as:

1. There should be at least three and no more than twelve children in a group.
2. Children are between ages two and six but classes of older children are being considered.
3. One child therapist is assigned to each classroom of up to twelve children.
4. Each psychotherapy session occurs only in the classroom.
5. If more than three children are present, two preschool educators are needed, to conduct educational activities while one child is treated at a time within the classroom.

6. Educational activities can occur daily for full classroom days which occur five days a week. They must occur at least two hours a day, at least two or three days a week, totaling at least six hours a week if there are eight patients.

7. In-classroom psychotherapy sessions must occur with each child at least two and preferably five times, each session on separate days of the week.

8. Each session should be preceded and followed by a “briefing” or “debriefing.”

9. Insistence is required on a child’s individual therapy taking place in the classroom in the presence of other children and teachers.

10. Weekly parent sessions must occur with a staff member, sharing what has happened in class and home, and most of those sessions should be parent-teacher sessions of at least 45 minute durations.

11. Weekly staff conferences are needed, sharing what has been going on with the treatment.

12. With parental permission, videotaping of psychotherapy sessions should be regularly used to assist at staff conferences, and for objective follow ups.

The method is based on a network of intersubjective influences, not just a therapist’s, teacher’s, parent’s or aide’s influence. In order to be sure that the RNT service is well set up, all the component pieces should be present and interconnected. If a certain piece of a network influence is lacking, a network’s communication processes might go down or be weakened. We aren’t sure why this is so. It may be analogous to an internet server’s disconnect causing a widespread e-mail outage or a broken wire causing lights to go out in a larger but highly connected electrical grid. The most likely influence to be lost is teacher-parent conferencing, as parents are often avoidant and teachers are not accustomed to parent interactions of weekly intensity. Yet there is data showing this factor is extremely powerful in the cognitive and clinical results.

Any RNT service should start with a daily class or classroom group which regularly meets two to five days a week. The method does well with a considerable age span (between 2 and 7) in a single classroom, a flexibility and inclusiveness which is partly due to the differences in children’s pathologies and developmental levels. Developmental and cognitive inclusiveness, providing a range of children’s ages, executive skills, and cognitive and emotional developmental stages is very useful to the treatment. Having such a mix of children in the classroom is often revelatory to a therapist as she or he may notice behaviors which indicate the child's perception of his place in his family, including sibling relationships. (Kliman and Ronald, 1970)

Staffing Requirements

Each class usually needs at least two teachers per classroom group (head teacher and assistant teacher) and a third teacher assistant if there are four to twelve children in the group. It is possible to have a very small RNT group, with only three children and one therapist and one teacher. Each class requires a psychodynamically trained child therapist, who must be in the classroom for a couple of hours each school day. The child therapist must have enough time to work at least 15 minutes and preferably 20 or more minutes with each child during each RNT service day–usually three to five times a week. The same therapist should be prepared to meet with each child’s caregiver or parent for 45 minutes once a month. The head teacher must be prepared to work with each group daily for at least two hours of each day classes occur, and to meet with each child’s caregiver or parent, for 45 minutes weekly.

Every effort should be made to keep staff changes to a minimum in the interests of a stable environment. Even a school teacher turnover rate of one change per semester is potentially detrimental, and a tally of any changes should be kept as part of the clinical and educational record keeping effort. Use of substitutes should also be tallied. At least 80% of the RNT school year should be conducted by a stable team. Summer programs are valuable supplements, which require some substitutions of staff.

RNT staff often experience accelerated personal growth as a result of an in-service effect from participation in regular briefings, debriefings, and staff conferences. Some otherwise relatively rigid therapists who feel uncomfortable or frustrated with primitive children find they can nevertheless work well with the emotional and social support of teachers. Teachers who started out knowing little about severe childhood problems ultimately develop profound understandings. More specific information regarding the training and supervision of staff, their distinct roles and responsibilities, and their combined collaborative influence as network therapy is discussed below.

Essential Procedures Include:

1. In-classroom briefing just before a child's psychotherapy session.

2. In-classroom psychotherapy sessions for each child, multiple times a week.

3. In-classroom psychotherapy (15 minutes or more) each day the class meets.

4. In-classroom debriefing immediately after the child's psychotherapy session.

5. In-classroom educational activities.

6. Weekly parent conferences: A 45 minute duration, three times a month with a teacher and a monthly parent conference with the RNT therapist.

7. Weekly Team conferences (therapist and teaching staff).

Briefings are structured times of in-classroom communication among at least two adults (teacher and/or parent and therapist) and the child right before the child's in-classroom psychotherapy session. These communications involve the teacher and child jointly narrating a summary to the child's therapist about the child's day so far. This briefing serves several functions for the particular child who is about to have a psychotherapy session. It gives the child practice in experiencing being thought about by two important adults (teacher and therapist) at the same time. He processes the emotional expressions as well as words of the two adults who are collaborating about him. He develops a theory of multiple minds. He has a chance to practice learning how two (and up to a dozen classroom people) can have caring and detailed knowledge of his behavior and shared but individually varied theories about his mind. During the next fifteen or twenty minutes, his psychotherapy session is necessarily influenced by his knowledge that he is being thought about and his expectation that this experience will occur every time he is in the RNT classroom.

The Pre-Session Briefing is followed by Play Therapy

Fifteen to twenty minutes of in-classroom psychotherapy is provided to each child for as many days a week as the class meets. All of the play therapy sessions take place in the classroom so that the real-life behavioral confrontations and insights developed with the child are shared and verbalized immediately with him or her and the teachers, in the presence of other children and some parents. It is critical that this is done regularly and right on the spot, before connection and meaning is lost to the child's immature memory and limited attention span or buried by such defenses as avoidance, denial, repression, isolation, dissociation or projection.

The Individual Psychotherapy Session must be followed by a Debriefing

The debriefing is an interpersonal event lasting a few minutes. It contains a structured effort to communicate. It provides the child with hundreds of opportunities in a school year to view, mirror and identify with others' feelings and behavior about him. The child and therapist endeavor together to speak to the teacher about the content and emotional tones of their session. When the child cannot or will not verbally narrate his or her own experience of the session, the therapist fills in the teacher, while in the child's presence. There is a deliberate recursiveness to this process, as each player has important input into the others' communications and other interactions and receives input about those which didn't directly include him or her. Other children in the classroom may be part of and listen to the index patient's psychotherapy and may hear and participate in the debriefing.

Location

RNT child psychotherapy sessions should always take place exclusively in the real-life space of the classroom, never on a pull-out basis. The location is essential, as in-classroom psychotherapy draws heavily on the therapist's and the child's shared perception and experience of the events going on in the classroom. These events often include other children entering into the index child's therapeutic conversations, as well as therapist and child talking together about other children and events they see going on around them in the classroom.

Control and Participation

The index child is the child who is therapist's primary focus during a therapy session. Other children will have their turns. They should be allowed to help the current index patient, but only to the extent they do not interfere with that child's play and opportunity for self expression. A participating peer must allow the index child to have his way in temporarily controlling the expressive process. Teachers and therapists unhesitatingly remove a disruptive child from the vicinity of the index child's session with the psychotherapist. In practice, most children are initially jealous of the classroom therapy time their peers receive with the therapist but usually become collaborative within a few days or weeks. Soon the children value the sessions so much for themselves that most children become altruistic, helping each other to have sessions, and becoming supportive of each other's efforts to play and talk during the classroom sessions. Videos show that children in a Reflective Network Therapy setting often help each other work at their highest level of abilities, and nurture each other. Within a few weeks, each child can be seen increasingly respecting the rhythms of the others and identifying with the helpfulness of the classroom adult helpers. The children's empathy, altruism and understanding of each other's minds are readily commented upon by the adults. Such commentary provides modeling as well as a behavioral reward for intrapsychic and interpersonal growth.

Reflective Network Effects

The network effect is enhanced on a peer level by allowing and encouraging children to hear one another's sessions, and to help the index patient play with others during his session in whatever fashion the index child chooses. This naturally multiplies opportunities for mirroring and mentalizing. Additionally, jealous or mean interference by peers tends to be remarkably infrequent once children settle into a new group. The network fosters a culture of kindness. Viewers of our treatment videos are often surprised by the altruism the children demonstrate. Because children learn to be reciprocally considerate of each other, collaborative and enriching behavior becomes self-sustaining.

Therapeutic Material and Frequency of Therapy Sessions

The content of therapeutic sessions must be as varied as the children themselves. Every child expresses different behavior, ideas and affects, and has different life experiences, developmental levels,

and life challenges. Therefore, a child's psychotherapy sessions should be dominated by the play, thoughts, themes and words of that one child.

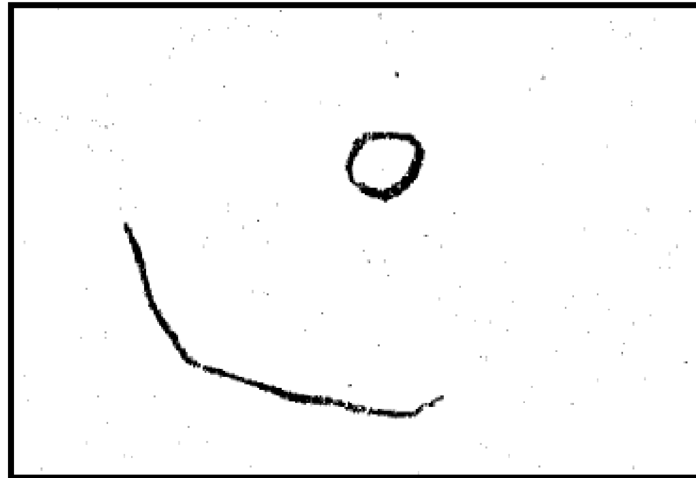

Figure 3.2 Child tells therapist about his drawing of a face without eyes: "That's you!"

In-class psychotherapy sessions should take place two or three to five times a week; the duration of each child's individual session is 15 to 30 minutes. These sessions usually follow a fixed schedule. Children's names are posted in the sequence planned for their sessions on the classroom chalkboard. Many children quickly learn to read all the names. Each child in turn becomes an index patient within the real life space of the classroom. The norm is that on any given classroom day, every child receives a session. The total number of sessions has an orderly correlation with outcome, especially of IQ gains, so we encourage more rather than fewer sessions. Reports by Marianne Lester, M.A. (Kliman 1997) of successful twice a week treatment have been confirmed by work of Tish Teaford, MFT intern, as studied by third party evaluators (Hope 1999). We have found that Reflective Network Therapy treatment usually requires at least a school year before there are lasting good clinical and cognitive results although clinical changes have often been much more rapid. The variation of clinical response velocity is immense, however. Linda Hirshfeld, PhD has treated a selectively mute girl, who never spoke in another school, yet she began to speak after a single day of Reflective Network Therapy! Other children keep growing emotionally and cognitively–slowly and steadily. A very few children have had two or more years of continuing RNT work. Zelman (1996) reports good clinical and cognitive results when preschoolers continue in after-school evening RNT treatment groups. The best documented success with a severely autistic child took three preschool years to accomplish, five times a week.

Essential Procedures Outside The Classroom Include:

1. Home visits before or at the start of classes.
2. Weekly parent guidance sessions.
3. Weekly staff conferences with review of videotaped sessions.

Home Visits during the Initial Evaluation Process

Home visits add greatly to teachers' familiarity with parents and children as human beings who can be deeply understood and with whom the teacher can compassionately identify. The visiting process sets an expectation that the parent will participate, and will do so in a natural way. The home visit takes place early in the evaluation process, so that teachers can be perceived by the child as knowledgeable,

friendly adults whom the child knows as part of the family's network. Sometimes parents are uncomfortable about behavior their child manifests during such a visit. The teacher is encouraged to let an uncomfortable mother know that the teacher appreciates her distress and that the teacher realizes there are many aspects of the child's behavior, only one of which is currently being shown.

The home visit is a good launching point for the first parent conference, when the parent can be encouraged to discuss differences in the child's home and out of home behavior. Teachers should engage in a home visit and all parent conferences with the assumption that the parents know a great deal about their child, and are the richest source of clinically and educationally useful information about the child's behavior. Should they find the parent's perception is distorted or unrealistic, this is an important concern to share with the child's RNT therapist. A team effort enhances a parent's observational skills, and supports a lifting of the parent's defenses against realistically perceiving certain aspects of the child's functioning. Sometimes the child is greatly underestimated or overestimated by a parent, or falls far short of expectations or ideals within the family, yet the child may have many undeveloped assets which the parent has not consciously attempted to cultivate. These are often easier to see during a home visit than in a strained new interaction with strangers on new turf such as a classroom presents to an anxious child.

While the home visit should occur early, it may often have to be delayed until parents have already visited a classroom and have decided to enroll the child. The parents are invited and welcomed into the classroom, just as warmly as is their child.

Weekly Parent Guidance Sessions

Weekly parent guidance sessions, 45 to 60 minutes in duration, are conducted mainly by the head teacher. Once a month, the parent guidance session with the teacher is replaced by an hour with the classroom therapist. Sessions usually occur in a private office within the school, but have often been effectively carried out in a corner of the classroom during classroom activities. Weekly parent guidance sessions start soon after the child's acceptance into the classroom, and the parent must be prepared to invest in the travel time and an hour a week with the teacher. Home or telephone visits for some home-bound parents can to some extent replace a session in an office, as can Skype sessions. Resistance to parent guidance sessions is often not only the parent's problem but a product of teacher's unfamiliarity with relating so intimately to an adult rather than a child. Thus, a therapist can useful supervise the parent guidance, during staff meetings.

Communication to staff about personal matters in the family and in relation to the child is difficult for many parents. Naturally, as trust in the teachers is developed, frankness and straightforward talk by parents becomes easier. Teachers will recognize the importance of regular meetings and setting an expectation with parents that such will occur. Teachers tend to need a good deal of supervisory support in the guidance process and are surprised by the importance of their work. Supervision comes from the therapist, who is usually experienced in parent guidance concerning emotionally disordered children. Often, teachers' parent guidance provides a supportive psychotherapy for the parent, who may grow a great deal as a result of sharing home and school information in two directions at the weekly meetings. Some parents use the guidance as an opportunity for psychotherapy, often including a spouse and other children in a family therapy. Alicia Mallo, MD (Director of Cornerstone Argentina) has been doing the majority of parent guidance sessions, rather than the teachers. She is skilled at family therapy and the families tend to be seen as highly dysfunctional in the population she serves. However, we prefer the predominant use of teacher guidance, as it may significantly enhance the network's modeling process and may explain why a greater number of parent sessions lead to greater IQ gains for the children.

A helpful parental guidance concept is that Reflective Network Therapy will make children more gratifying to their parents. It allows love to flow in both generational directions. This view helps parents be motivated to participate in the treatment. It reduces premature terminations of treatment, which can occur when a child is making progress and becomes more demanding and expressive of developmentally advanced needs. Some parents wish their children to remain immature and dependent, and experience a sense of loss when the children grow. A good relationship with a supportive teacher growth-promoting

helps compensate for this parental sense of loss. During parent guidance, some parents receive enough support and nurture from the teacher that they are helped to realize their own mental health needs and allow themselves to seek more in-depth psychotherapy by referral.

We are reluctant to accept and maintain a child in RNT treatment whose parent will not attend such meetings. That reluctance is explained before acceptance.

Staff's Weekly Review of Videotaped Sessions

It is enormously helpful to have a video camera and videographer available at least weekly. The videographer is often a parent, but lay volunteers, clinical or education students, and cinematography interns can do the job as well. Confidentiality agreements are required and legal requirements for working with children should be met by volunteers (fingerprinting and criminal record clearances included). The videos should be used regularly in weekly staff conferences. They provide a reflective stimulus which encourages professional understanding of the children, and to track the progress children make over the course of their treatment. Videotapes are extremely helpful for supervising teachers and therapists during their training. Videotaped records of work may also have many values for objective research purposes.

Classroom Environment

The environment is cheerful, busy, colorful, at times noisy, but surprisingly quiet at many moments, and generally kept neat and orderly. There is a strong emphasis on early childhood education. A room 12 x 30 feet or larger is needed for eight children, two teachers and a therapist. Access to an adjacent outdoor play space is desirable. Even more than in most preschools, the RNT classroom must be well-equipped for expressive play as well as for formal learning of skills.

Figure 3.3 Drawing by a severely traumatized child. The sublimative material in this drawing is not readily apparent: an example of why only the therapist should make interpretations to the child.

Classrooms should include the following items for expressive play: play dough, paints, clay, water, blocks, dolls and furnished doll houses, puppets, comforting stuffed animals, toy vehicles, blankets, and a variety of dress-up clothes and hats, as well as housekeeping supplies like toy dishes, tea sets, brooms, and the like. Designated areas should be set up for special activities such as dress-up or block building. Water play and sand tables are helpful.

These play and formal learning resources allow immature children much gratification and comfort, and allow more developed children to regress constructively. They stimulate imagination and encourage creativity. Developmentally progressive and advanced learning materials such as Lincoln logs, puzzles and games should be readily available to round out a good preschool environment. We have found that some overanxious and some autistic children, dislike their work to be permanent and enjoy using an Etch-a-Sketch apparatus, which they can erase at will. Some children benefit from learning programs on computers. Others cannot do art work on a computer, but can work with crayons or paint. A digital camera to preserve an image of quickly destroyed art work can be helpful in allowing a child to tolerate the viewing, and in showing him or her that the teachers and therapist are thinking about his products.

Safety Considerations

Staff screening by interview and reference-checking is not enough. We urge, whether or not local laws require, that all U.S. facilities staff and volunteers must be processed by fingerprinting by the U.S. Department of Justice, which will reveal disqualifying histories such as felonies.

The classroom should be safely and appropriately furnished and supplied, meeting the local licensing standards for a public or private preschool or day care center. If the classroom is in a mental health clinic, as a minimum, safety standards for a group therapy room in a mental health center may be used. Running a free-standing, non-public special education school may require sprinklers, fire alarms, special exit doors, and a certain square footage of outdoor space. Staff should have lockable doors on their toilets, but children are at hazard if they can be locked in a toilet stall. In facilities our agency developed we had “line of sight” access to the children at all times. There was supervision over the children’s bathroom activities by having partly open child lavatories and child size toilets, visible from a corner of the largest area of our classroom. Line of sight policy – allowing children to be seen at all times in all places within the school -- is a good insurance. It prevents a predatory visitor, parent or staff member taking sexual advantage of a child (something we fortunately have never had happen) and against a physical accident to a child occurring out of sight.

Referrals to Reflective Network Therapy

Referrals may come from many sources: pediatricians, psychotherapists, parents, day care personnel, nursery school teachers, public school personnel, family therapists, private preschools, case workers, family friends and other parents. Within one public school system, we worked in one project for six consecutive years on an Individualized Education Plan (IEP) basis; that is, each and every one of about 40 children were sent to us by teams of public school personnel who recommended our special program to parents.

Class Composition

Social, racial and ethnic diversity should be valued. It has varied greatly in different sites. At times, the majority of our children in have been African-American offspring of single mothers who were socioeconomically stressed. Sometimes many children were in foster care when we treated them with RNT. At other times, the majority of our children have been from Caucasian, two-parent families whose financial circumstances were middle class or even very wealthy. Many successful applications of RNT have been in projects serving children from a wide range of ethnic backgrounds whose families were in various socioeconomic circumstances.

The diagnoses of the children receiving RNT has varied greatly. Zelman (1996) reported that 50% of the 42 twice-tested New York Cornerstone children about whom he wrote suffered pervasive developmental disorders. Therefore, we estimate conservatively that 25% of his cases (10) had PDD. Hope (1999) reported on a consecutive series of ten twice-tested children with pervasive developmental disorders. Most of the Cornerstone Argentina children treated by RNT and those treated at the Ann Martin Center (California) have pervasive developmental disorders. Only a few of the children treated so far at Wellspring (in Seattle) have that condition.

While the outer age limits are two and seven years, the younger the children are, the smaller the total number in the class should be. That is especially true if these very young children are seriously emotionally disordered or highly developmentally disordered such as children at the severe end of the autism spectrum. Small class sizes also work best for highly aggressive or destructive children, but introducing one such child at a time into a large well-functioning group is very feasible and often quickly calming for the child.

As for gender (as in the group of children discussed below) the majority of children referred to RNT services have been boys. Ordinarily, all sources of referrals (including referrals from private day care centers, preschools, kindergartens and pediatricians) tend to identify more young boys than young girls who are inattentive, difficult, aggressive, overactive, obstinate, highly withdrawn or on the autism spectrum. The same is true of children referred for RNT based on public school IEP’s (individual educational plans) in public school preschool and kindergarten years. Children with autism spectrum disorders, are disproportionately male, are a growing population and are usually in need of special

education. Although our ideal would be to have equal gender ratio, and a broad range of abilities, given the gender proportions of the difficulties RNT best treats, we accept and encourage all workable combinations of children into the RNT classroom.

The Role of Parents in the Classroom

Parents are valued team members and participants who are absolutely essential to the network process that heals children treated with this method. In addition, parents are themselves fortified in the process, bolstered to continue their challenging parenting roles even more fully. Parents should always feel welcome in the classroom.

Parents are encouraged to stay with their children for several days at the beginning of a child's experience in RNT treatment, if at all possible. Later, parents may just drop the child off. The daily parent-teacher briefing which occurs when a parent drops off a child often takes just a minute but is an important structured opportunity for the parent and child to be impacted by witnessing reflective network therapy time and again. In addition, the content of those parent and teacher briefings are often used to accelerate the child's recovery. For instance, Oscar's mother (whose case is discussed in another chapter) provided critical information about specific family violence which immediately enhanced the therapist's ability to interpret the child's social difficulties and violent, frenetic behavior. During parent guidance sessions as well as in class, this contributed much information about Oscar's anxieties concerning body integrity in the face of family violence. Over time, she was also rewarded by the child's growing social abilities and ability to express tenderness.

Parent Involvement at the Beginning of Treatment

The acclimation process is structured to include the child's parent(s). Parents (or primary caregivers) should be prepared to do the following during the first week:

1. Come into the classroom and try to be themselves with the child.

2. Introduce the child to the staff and other children.

3. Get settled in the classroom for a few hours during each of the first days their child visits.

4. Observe what is going on.

In addition, we require every family to have (or to have recently had) a pediatric evaluation of their child in conjunction with the onset of a child's intake for RNT treatment. There is no point in treating a child without knowledge of the child having petit-mal epilepsy, metabolic cause for behavioral problems, Rett's Syndrome, Kleinfelter's syndrome, thyroid problem or brain tumor. Such important diagnostic omissions can usually be addressed by a good pediatric evaluation and medical treatment plan.

Ongoing Parent Involvement

After the initial period, the parent should expect to continue to communicate history to the teachers and therapist, including a history of their relationships to their children and their behaviors. This history goes back into pregnancy and previous generations, including genetic endowment, if known. Important physical influences or disorders the parent has or the child has developed have to be considered with the parent's help. These include prescription medications tobacco, alcohol or illegal drug exposure in utero, and metabolic disorders which may not have been known or disclosed before. Usually these have been well excluded by obstetricians and pediatricians, but the reflective network team will want to make doubly sure since parents sometimes only gradually disclose physical and environmental factors which contribute so much to childhood behavior or disorder(s). History of the parent's own

traumatic childhood or psychiatric disorders may be late in being confided, but will help guide the child's treatment.

Each morning, parents are expected to come into the classroom and spend a few moments briefing the teachers about how the child has been feeling, behaving and verbalizing during the previous day and evening. These early morning briefings are often essential to the children's treatment and education. Parents routinely participate in the classroom at least periodically thereafter, frequently listening in and talking with the staff about their children during the course of classroom activities. Weekly parent guidance sessions must be attended. Parents should welcome routine home visits (usually by teachers) when indicated.

Parents are often invaluable classroom helpers with practical matters such as operating a video camera or assisting other families during family emergencies.

In some teams, monthly all-family meetings are held at the end of a school day, in the last 45 minutes of a class session. These meetings are usually quite popular, and involve all the children, with sharing of children's progress and problems, and often a sharing of family news and school news. Zelman (1996) held such evening groups weekly for years after the completion of the preschool programs, scheduling parent conferences for evenings, and found that these sessions were significantly associated with high degrees of IQ growth.

Parent Guidance Conferences

Once a child has been evaluated, there is an ongoing parent guidance process in which both the teacher and therapist have roles. The staff finds it easier and easier, with experience, to be respectful of each parent's burdens and knowledge concerning their child. Parent-blaming and adultophobic attitudes that might be present, (and at one time were common in psychotherapeutic and educational professions) are easily lost with training and experience. Staff becomes increasingly sensitive to parents' attitudes toward living with a difficult and changing child, fluctuating mutual dependency needs, and often sudden shifts in aggressivity and affection. Staff develops a heightened awareness of the parent's ability to make critical contributions to the child's recovery.

The staff-parent meetings require sympathetic listening, sharing observations, helping parents to carry insights gained in the classroom into the home environment and supporting parental capacities and responsibilities. Since this method depends on a network influence, the teacher must model good communication skills during these meetings, conveying to parents much about how she/he thinks and feels about the child. Helping parents accept their child's perceptiveness about home adversities and changes is routine. Helping the child mentalize those experiences in child appropriate doses in the classroom occurs as it arises, and parental support of this process is essential. During parent conferences the teacher will try to convey information about the child's intersubjective life in the classroom to the parent, making a bridge between home and school. The teacher's verbalizing of this information to the parent places the child's functions in a developmental framework which a parent might find more difficult to conceptualize without help from the teacher. The Reflective Network Therapy classroom teacher's parent conferences (three conferences per month) have four main functions:

1. Receiving information from the parent about the child and current family events.

2. Sharing information with the parent about the child's classroom experience.

3. Giving educationally oriented developmental guidance.

4. Giving support to the parents or parent surrogates.

During conferences with RNT teachers and monthly conferences with their child's RNT therapist, parents receive deep emotional sustenance. That sustenance is often required to set up a constructive nurturing cycle of reciprocal love and caring with their children. The failure of a child's reciprocity is depressing and depletes many parents. The therapeutic team should assume that each parent needs and deserves such support in order to care for very troubled children. Each parent has the burden of living with a child whose emotional life is difficult to support, and whose relationships are layered with resistances and problematic neurobiological complexities. The child's special assets and deficits, as well as their communications, are often puzzling and quite different from what other families experience. Most parents of such children have been previously frustrated, disappointed and discouraged –and sometimes immobilized– in major aspects of their relationship with their children, no matter how much they love them. Parent guidance sessions go a long way to mitigate their resulting pain and confusion. Strengthening the child's primary support system in turn strengthens the possibilities for the child's home environment to be as nurturing as possible throughout the child's treatment.

Parent conferences are conducted in private if possible. Again, the teacher sees the parents or primary caregivers (both parents if feasible) three times a month for conference. The therapist meets with parents once a month and the teacher does not hold a parent conference on the week that this occurs. Current information, current events, and earlier events of importance are reported on this weekly basis to the teacher and are transmitted to the therapist for use in his or her daily work with the child and in the therapist's monthly sessions with the parents. The child knows that Mommy or Daddy, or whoever sees the teacher, sees the teacher regularly and that the teacher and therapist share information directly with the parents or caregivers. The teacher helps the parents understand the needs of the child, especially how to cope with the child's developmental process. Some parents must be helped to know the difference between what constitutes normal development and what is peculiar to their child. The parent is empowered to cope with the child's difficulties as well as changes on a day-to-day basis and acknowledged for doing so.

Changes in the child's affect or behavior which are actually changes toward health and recovery can be confusing to parents. Many parents often have a difficult time accepting changes which are actually positive movement toward recovery when the changes (which can be quite sudden) are not discussed and explained. After years of reacting to dysfunction, parents may experience temporary difficulty adjusting to healthy changes. Or, perhaps the parent needs help to move quickly from needing to be primitively needed to taking pleasure in developmental milestones which put new demands on them to change in response. This resistance can be a normal, brief adjustment period that parents can traverse quite easily with guidance. Sometimes parents may have other complex issues which manifest as resistance to changes in the child. In either case, conferences with the therapist support parents through the changes to achieve a healthy, joyful acceptance of their child's achievement which reverberates back to the child. Sadomasochistic and other parental complexities are sometimes confided, leading to constructive referrals to outside therapies for the parent (Kliman, 1970).

The child's ability to deal with his or her family members in a positive way is promoted through staff support of positive parental responses. Parents can verbally vent their feelings of frustration and anger at the child, during parent guidance, and these expressions are accepted and given an interpersonal reflection and perspective by the teacher. An important ramification of the teacher's role in such conferences is that helping parents understand and continue to participate in knowing about and informing their children's therapy supports the child's entire developmental process. The teacher is trained to accept the parent's feelings and work with the parents' concerns, including criticism of the therapist. Criticisms or concerns about the other children, or the program are also dealt with and accepted, thus helping insure continuity of the therapy.

Parent conferences aim to include and coordinate with mothers, fathers, grandparents, and any others directly involved in day to day dealings with the child (including social workers, and the like, if appropriate). Through daily contact with parents and surrogates who bring the child to school, as well as through weekly parent conferences, the teacher can model good parenting to worried parents with difficult, puzzling, atypical or slowly developing children. The teacher's acceptance, genuine affection and

feeling for the child, and her ability to influence the child's behavior provide an important model for frightened, discouraged, and angry parents. Parents gain more realistic expectations and perceptions of the child through the eyes of an interested and concerned teacher.

Boundaries between generations are often a subject of teacher guidance with parents. Sleeping arrangements, viewing of parental sexual activities, perception of sexually explicit, disastrous, violent or frightening news and otherwise inappropriate television programs is often a shared concern constructively dealt with in weekly meetings. What the teacher learns about how the child gets along with other household members, pets and neighbors impacts the content of therapy in many cases, and provides parallels with classroom activities. Thus, the teacher can make a data-rich contribution to the team, enriching the child's therapists understanding of social disabilities and developmental lags in ways that are real and immediate for the child.

Although the parent guidance focus is on the child, in order to support the healthy changes for the child, the teacher must develop empathy for the parent. For example, a mother has a child who will not go to sleep, but the mother wants to watch an inappropriately sexy or violent TV program which would further make it difficult for the child to sleep. Guiding the mother or father with sensitivity to her/his own point of view, while considering her needs, is more helpful than guidance from a totally child-centered position. Sympathy for her interests and needs will help her delay her own gratifications when this is in the child's best interests. Unless a parent feels respected, appreciated, understood, and nurtured, she or he is unlikely to respond to guidance or make any lasting positive changes that might be needed.

Assessment and Treatment Planning

Evaluations: Several forms of evaluation must precede a full RNT treatment planning for each child. Staff needs to determine a child's diagnosis, look for causal or contributing factors (such as genetic contributions, traumas and family adversities) and sources of strength and resilience, as well as family and child treatment needs. We conduct an examination of each child, usually right in the classroom, videotaping the interview and the child's behavior in the classroom. The parent is present during this initial interview. There is usually a class in progress, so we can assess interactions with other children. We review previous evaluations done by others, contact previous treating professionals and schools, and use several psychological and educational assessment and testing tools. Assessment tools include: The Achenbach Child Behavior Checklist, standardized questionnaires, psychosocial and developmental history forms, Childhood Autism Rating Scales (CARS), and a questionnaire called "Your Child". If the child is capable of being IQ tested, the initial evaluation will include a baseline cognitive assessment using the Wechsler Intelligence test for Preschoolers (WPPSI-R or its latest iteration). In less cognitively competent children, a Vineland Inventory is helpful. The child's behavior in an ongoing RNT group may help a great deal to decide whether a child can be helped in the RNT classroom, or by what other means.

While important components of the evaluation take place during the initial home visit and within the classroom group setting, an initial and carefully detailed history taking from the primary caregiver(s) is usually better done with a degree of privacy more easily obtained in a side room. The evaluating therapist enlists the teacher to conduct part of the initial history taking and observation and gives the teacher clinical input as to the styles and needs of the adult caregivers and the child.

The therapist is more experienced diagnostically and is ultimately responsible for the intake evaluation, including history taking from parents, direct examination of the child, diagnosis, and consultation as needed with other professionals. For therapists who are conducting this work, we suggest the diagnoses used in initial and follow-up evaluations, including quarterly evaluations should closely follow the American Psychiatric Association's Diagnostic and Statistical Manual, version DSMIV-TR (2000).

Criteria for Appropriate Placement in Reflective Network Therapy

The therapist is ultimately responsible for the final decision regarding appropriateness of accepting a child for a trial of treatment. If circumstances or evaluation results exclude participation, alternatives to RNT should be considered and recommended, such as referring for primarily psychopharmacologic treatment or other procedures. These procedures may be neurological, psychological, genetic or metabolic studies regarding possible reversible or irreversible disorders. The following inclusion (admission) and exclusion criteria are applied.

Inclusion Criteria:

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. Siblings of severely disturbed children have been also been helped by Reflective Network Therapy. Emotionally healthy foster children and children of staff have been welcomed. The following are suggested optimal but not absolute criteria:

1. Evaluation has been agreed to or already performed by a pediatrician, licensed psychologist, or child psychiatrist, or other clinician, or else an IEP (Individualized Education Plan) has been provided by a public school district. Evaluations optimally start soon after the first visit to the classroom and ideally soon include the Wechsler Preschool (WPPSI-R), and/or similar IQ testing.

2. Children can be accepted with a wide range of diagnoses. Commonly, one or more of the following has been diagnosed or broadly categorized: SED, PDD, an emotional, developmental, behavioral or psychiatric disorder, or an expressive or receptive language disorder.

3. Receptive and/or expressive language is (or was, before symptoms began) at least at the two year level. Exceptions can be made if the child appears related to other people. (Cornerstone Argentina and other sites are accepting children who do not meet this criterion, and we are following their preliminary results with appreciation.) Children with complete, selective or elective mutism are accepted.

4. Parents or guardians are willing to permit professional supervisory, educational and scientific use of closed circuit and videotaped study of the child's treatment.

5. At least one parent or caregiver agrees to participate in weekly guidance conferences concerning the child's needs and progress.

Exclusion Criteria used by most RNT service sites:

The following exclusion criteria are best considered following several in-classroom observations of the child:

1. Severe autism, with the child having no useful language by age five, nearly constant occupation with stereotyped behavior such as whirling and twirling, little eye contact, little symbolic play *and* no sociability for the previous six months. (Cornerstone Argentina is accepting exceptions to this criterion and seeing important improvements in some children).

2. Persistent or severe dangerousness to others during the past few months and during in-classroom visits to the RNT group.

3. IQ or Developmental Quotient is or appears to be under 50 and the testing psychologist has the opinion that the child will probably not be testable by Stanford Binet or WPPSI-R protocols within the next few months. [For examples of exceptions, see the complete recovery in the case of Dorian Tenore-Bartilucci in chapter 4 of *Reflective Network Therapy in*

the Preschool Classroom and the IQ rise and clinical progress in the case of "J." included in a report by Fran Morris in this manual.]

Individualizing the Treatment Plan

Planning for a predominance of social and cognitive education at one extreme versus predominance of dynamic and interpretive psychotherapy at another extreme requires asking oneself (as a therapist) "Can the child understand abstractions?" If so, can the child use interpretations?" Many children cannot even understand concrete words when they first start RNT treatment. They must be helped to learn to mentalize and form abstractions about their behavior. They need lots of practice in placing thoughts and emotions into words. Nurturant corrective relations work and the mentalizing functions of early childhood education as well as therapy will predominate over dynamic therapy for a long while in some cases. The therapist and teachers routinely and intentionally provide the children with modeling, practice and support for mentalizing.

Staff Prerequisites

Therapists who are candidates for certification in Reflective Network Therapy should have already had some psychodynamic or psychoanalytic training. The value of interpersonal therapy should already be appreciated, as well as the value of insight. A prior experience with family therapy training or network therapy training would be valuable. Clinical licensure is required for RNT therapists, unless they are supervised by a clinically licensed person weekly. Appropriate licenses are MSW, LCSW, MFT, PhD or Psy.D., MD, or DMH. Psychology and MFT interns have been accepted into closely supervised use of RNT on field placement basis, and we see no reason why this could not extend to LSW interns.

A potential RNT therapist usually already knows the basic features of child psychopathology and family process, and has already done some child and family therapy. Ideally, the therapist is or is becoming an independent diagnostician capable of conducting several forms of psychotherapy. Some talented persons with insight about their own psychological processes can carry out the method with supervision, without having had psychotherapy themselves. A supervisor could best determine whether the particular therapist is achieving sufficient understanding to practice RNT on this basis. However, a beginning RNT therapist's prior training should ideally include psychotherapy or prior psychoanalysis for the therapist. This is desirable in order to achieve an adequate understanding of transference and countertransference processes, and it is preferable that the therapist have had such psychotherapy or psychoanalysis during a time when he or she was actually doing psychotherapy with children. Clinical licensure is not a guarantee of this experience.

In addition to selected readings, new therapists and their team's teachers are supported by the following tools and procedures for training:

1. A three-day intensive seminar in the RNT method is taught by a senior RNT therapist and teacher who have successful experience applying the method. A Reflective Network Therapy training seminar covers several diagnostic categories of treated children, the work of several different teams, illustrates adaptation of the method to different physical sites, and includes presentation and discussion and study of videotaped documentary of children's RNT psychotherapy sessions.

2. Studying and applying a spectrum of RNT techniques in the classroom under supervision. Primary source material for that purpose consists of an archive of training videotapes from the Children's Psychological Health Center, Inc. which illustrate those techniques with children treated in other Reflective Network Therapy classrooms who had a variety of diagnoses and disorders. Training tapes include portions of actual briefings, debriefings, and full therapy sessions with individual children in the classroom. Training videos demonstrate dynamic techniques, children's immediate responses, therapeutic turning points, and long term changes.

These videotapes are selectively made available only to credentialed mental health and educational professionals and to interns and students who sign a binding confidentiality agreement.

3. Continuing supervision by an RNT therapist or teacher for the first year of practice. Supervisorial feedback and guidance is based on review and discussion of videotapes of RNT work with children performed by the trainee team member(s). A minimum of 10 video recorded hours of actual work performed by the trainee will be provided to the certifying supervisor for such review.

4. The therapist will be reviewed and guided to perform periodic assessment and record keeping. Therapists (or visiting consultants who are psychologists) will assess children's progress according to established clinical standards and will contribute to outcome studies, and follow-up studies (using IQ testing and other tools.) Minimally, a therapist will keep a problem/symptom checklist and rate changes quarterly, as well as making a DSMIV-TR axis 5 rating (Children's Global Assessment Score) based on behavioral observations. Maximally, a well trained psychodynamic or psychoanalytic therapist may keep a Hampstead Profile, which is a complex description of many psychological functions (A. Freud, 1962; Nagera, 1963) on each child, as well as quarterly clinical summaries containing a problem/symptom checklist with ratings of change, and a consideration of changes in object relations (e.g., from narcissistic to altruistic), ego functions (e.g., degree of reality testing, which defenses are used and which predominate), superego functions, psychosexual theme levels, and transference processes. At the Center for Preventive Psychiatry, abbreviated Hampstead Profiles were designed and used quarterly, (Kliman, 1972).

5. The therapist will be guided in all aspects of her or his responsibility to provide clinical leadership of the team.

6. When additional or further services are needed, the child's RNT therapist should take the lead in that process. The supervisor will discuss any such referrals with the therapist during the training period.

During supervision of a new team, the supervising therapist is responsible for monitoring the work of other team members sufficiently to determine whether a team has replicated the method. This is important not only for quality control, but also for scientific purposes, as comparisons of results amongst methods depends upon careful replication criteria.

In general, we recommend that the therapist be trained to focus on a child's interpersonal relationships and communication of here-and-now play and emotional process. Ideally, with eight children in the group, the therapist would be responsible for 160 minutes or two hours and forty minutes of therapy per therapeutic day in the classroom. This calculation is based on:

1. Twenty minutes per child or 160 minutes in the classroom per day including briefings and debriefings with child and teachers. In five days a week there would be 800 minutes or 13.3 hours of in-classroom psychotherapy given to the eight children.

2. Two hours a week or eight hours a month of parent guidance and at least one and a half hours a week of leadership at a team conference.

3. An additional minimum of one hour a week for other patient related duties should be allotted as well as, and one hour for miscellany. At least one hour a week of clinical record keeping is necessary.

The total time demands on the therapist are approximately 18-20 hours per week to serve eight children, seen five times a week. A typical breakdown of the therapist's time for a class meeting 5 days each week with eight children is expressed in Table 3.1.

Minimally (in a classroom group of less than eight children seen daily), a therapist could do useful work for example with four children, meeting only three times a week. This minimal intensity and minimal case load would require a therapist position of at least 8.5 hours per week. Many doctoral candidates could usefully take on this level of work successfully. On a per child basis, the therapist's time in this scenario is just over two hours per child. This calculation is tabulated above as 80 minutes a day for three days per week in the classroom (4 hours/week). The difference between this small and less than daily case load of four children and a larger case load with daily treatment of eight children is 8.5 versus 19 hours. In the ten hour differential, much more intensive treatment and much more likely measurable progress is provided for four more children. The intensively (daily) treated children are more likely achieve more IQ growth as well as mental health improvements Therefore, we strongly recommend the four to five times a week model to realize maximum cost-benefits for a group of eight children. Multi-site outcome data provides evidence that the more intensive treatment plan is optimally effective for IQ growth and probably for clinical change as well.

Clarification of Roles and Responsibilities

The roles of the teacher in the RNT classroom are many. She or he has roles as a reality oriented educator, as communicator between the patient and the therapist, as a stimulator, receptor and observer of communications and behavior, and as an observer of responses to interpretations when those responses occur after the therapist has left the classroom. The synergistic division of roles is respected in Reflective Network Therapy. Therapists are not trained as educators in the formal sense. Therapists use a broad repertoire of psychotherapy techniques individualized to a particular child. Cognitive restructuring, dynamic interpretations, and transferential interpretations are feasible within RNT (Kliman, 1970). It is essential to the method that the respective roles of the teacher and the therapist are made clear for the children. The children learn that the therapist is there to talk about, interact with, interpret and clarify the child's behavior and thoughts. They know the teacher is there for educational tasks, in the broadest sense, as well as for discipline management. One child showed his clear understanding of teacher and therapists' different roles as he finished a block building and said to the teacher, "It's my turn to be with Dr. K." He pulled a rocking chair over to Dr. Kliman, who was sitting nearby and said to him, "Let's work," and began to talk about his dream of the previous night" (Kliman and Ronald, 1970). The children are also aware that the teacher and therapist share information about the child as equals in the reflective network. The child not only witnesses this but participates when this sharing occurs during briefings and debriefings.

The teacher is responsible for developing and implementing the curriculum and educational plan appropriate to each child's abilities and for supporting the expectation of progress in socialization. The teacher advances curriculum implementation by constantly adjusting to children's responses and performance. For example, most children are expected to and sit in circles for such activities as "dress the weather man" with weather-appropriate clothing each morning. If they can't do it, teachers will verbalize the expectation that the children will be able to succeed in this group activity some day.

The teacher prepares the children to adapt to transitions without emotional upset. For example, children are helped to learn about the calendar and time, and to anticipate the rhythms of weekends, vacations, and each other's absences. The teacher helps build ego strengths related to handling transitions involving gratification delay. She regularly helps a child learn how to wait or how to share. The therapist will not teach but will interpret a difficulty in sharing or waiting, the more so as the child becomes increasingly aware of the functions of sharing and waiting. The teacher models good reality testing and good communication about realities. There is much value in teachers talking to children in small groups the about the unavoidable upsets that inevitably occur, such as a teacher's illness, a pet's death, a birth in a family, or the hospitalization of a parent or grandparent. Such discussion psychologically immunizes children against being overwhelmed in the event of any future, more destabilizing events (Kliman, 1968).

In their essay on this subject, Kliman and Ronald (1970) noted: “The educational program additionally consists of helping the child to explore the real world around him, with all the ramifications of learning to develop logic, order and problem solving ability as related to his world.”

The teacher is responsible for providing a program designed to promote the social, emotional, physical and cognitive development of each child. In this setting the RNT therapeutic teacher also assumes the traditional educator’s role of providing a socializing influence by managing children’s disruptive or aggressive behavior. This management of classroom discipline frees the therapist to do his or her interpretive work without the complication of distractions irrelevant to the children’s psychotherapy sessions. The teacher’s opportunity to work daily in such tandem with the therapist in a preschool setting is a core part of this method. It resembles the use of life-space interviews in psychiatric hospitals. For example:

(1) The teacher has primary responsibility for limiting the child who wants to challenge the safety of the group. The therapist interprets the motive for provocation and the associated fantasies of abandonment or injury.

(2) For the borderline psychotic, immature or regressed child, the teacher verbalizes differences between fantasy and fact. The therapist is freed to interpret the child's feelings, fantasies, and reactions.

Minimally a teacher’s record keeping includes maintaining daily attendance sheets, and writing several sentences about each child in daily educational logs. These records are kept in a child’s private file along with summaries of meetings with the child’s RNT therapist. In addition, Content of parent-teacher conferences are briefly noted and shared with the child’s Cornerstone therapist. Maximally, in terms of record keeping, teachers will create educational progress reports which are curriculum-based and which include standardized achievement test data, socialization ratings, and behavioral standards achievements for the individual child.

Teachers (particularly head teachers) are expected to become familiar with and able to describe the psychological history of each child. Teachers must also be able to meet for three quarters of an hour with each child’s family three times a month and for ninety minutes with the psychotherapist on a weekly basis. Teachers focus their parent guidance on developing a network effect in which the teacher and parent share essential new information about the child’s life and behavior with every other member of the team. As detailed in the discussion of parent involvement above, the teacher has key responsibilities for supporting the parents/caregivers and expanding the therapeutic network’s access to information during daily briefings and weekly private parent guidance conferences. The teacher also supports the role children can serve as peer helpers (co-therapists) for each other’s healing and recovery, under the therapist’s supervision.

Even children with low cognitive abilities are often aware of external catastrophes in the surrounding society, (Wolfenstein and Kliman, 1965; Kliman, 1968; Kliman et al 2001; Kliman, 2006, 2010). External catastrophes such as wars, major political events, acts of terrorism, and natural disasters should be discussed in with the children to the extent that teachers find it possible to introduce structured adult-led curriculum on those subjects. Children will often sense changes in the therapeutic milieu when the adults carry an emotional response to external events. They will also know when the team is experiencing distress or friction within itself, whether it is accepting of its members, or whether the team is in a conflicted state. Weekly team meetings provide an important opportunity to resolve such difficulties as well as to share new information about child patients.

If something terrible and perceptible happens to a team member, it will usually be necessary to communicate with the children about what they have perceived. For example, at the beginning of one school morning, a teacher learned of the sudden and unexpected death of her husband. The children witnessed her shock and weeping just before she left the classroom in distress. We found it useful to

share that tragic event in child-appropriate doses. The psychotherapist cancelled previous appointments for later that day in order to be maximally available in the RNT classroom. Parents were briefed by phone and the event was discussed when they arrived at the school with their children. The second teacher immediately organized classroom discussion about the bereaved teacher's evident distress, which was helpful to the parents as well as the children, allowing them to understand why the teacher had been crying and then abruptly left for home. Numerous resonations occurred within the children's subsequent RNT therapy sessions, which were useful for each of them.

Teacher Training and Supervision

Head teachers must be licensed in their state or supervised by a state licensed teacher, and have training appropriate to the age levels of their pupils. Ideally, Special Education Certification is desirable for the head teacher, though we have had only three such head teachers among our teams. At first, new RNT teachers study actual treatments by viewing selected training videotapes. This is essential for understanding how the method is carried out. Ongoing in-staff training includes weekly review of current treatments, which have usually been videotaped, at least once a week, during team meetings.

The therapist supports and guides teachers to develop or deepen skills, to achieve performance expectations and to learn Reflective Network Therapy techniques and practices both explicitly and through modeling. Briefings and debriefings and working in tandem in the classroom provide opportunities for on-the-spot teacher training as do the weekly staff meetings. Most supervision of teachers by RNT therapists involves sharing information and keeping each other's knowledge synchronized in the sense of being up to date about the cognitive and therapeutic status of each child. The therapist has an important need to have each child's therapy informed by the teacher's observations during briefings prior to a psychotherapy session. Therefore, the therapist must help the teachers to put their observations into the therapist's sphere of knowledge during briefings and conferences, and, in turn, help the teachers increase their observational skills. Generally, teachers need very little supervisory help controlling children's impulses and promoting or assisting with the development of socialization. This actually may come more easily to teachers than to therapists. Teachers are already trained to be instruments of socializing through group education as well as individual cognitive development.

Often, the mere process of talking about and increasingly understanding a child opens the gates of tenderness, so that all parties can be more affectionate to the child and in turn the child becomes more responsive to classroom discipline. As indicated, some supervision occurs right in the classroom. For example, the therapist may discuss a child's problem behavior with him, right on the spot, and ask the teacher for help with the behavior, or suggest a way the teacher and child could enjoy each other in a manner more therapeutically beneficial to the child. During supervision, a therapist may support a teacher's efforts, and tactfully suggest any ways in which the teacher might be inhibited about containing a child's impulses.

Ideally, supervision is a two way process. The teachers learn from the therapist about the child's diagnosis, causal factors, and family influences, and the therapist gains from the teachers a broad view of the child's behavior which occurs when the therapist is not present, not observing or interacting with the child. The teachers know a great deal within a few school days concerning how the child relates to them, family and peers. However great their observational contributions are, teachers may need some support to be understanding and supportive with parents. The head teacher plans the curriculum and is usually best equipped to supervise other teachers and have an overview of what transpires in the classroom. The teacher's assistant (as well as any interns or students) can give one-to-one attention to creative projects with a designated child but must be carefully supervised as he or she may not have a sufficiently deep understanding of what is appropriate in a therapeutic classroom or skilled in supporting the child in returning to group activities.

It is extremely rare that a trained preschool educator might be assigned who is deficient in the level of empathy and understanding the therapeutic educational environment requires. We have

encountered only one instance in which the therapist had to take the lead in replacing a teacher for a Cornerstone group.

Interdisciplinary Team Collaboration: Teacher-Therapist Synergy

Maintaining rapport among all team members is crucial to the RNT process. In weekly conferences a candid look at the team process enables each member to gain understanding and support to correct for perceived deficits, in the network's functions. While optimal functioning and harmony preserves the appropriate Reflective Network Therapy classroom environment at its highest level, it is sobering and humbling to realize we cannot always live up to our highest standards. Humility adds to our flexibility. Thus, beginners need not fear RNT.

Communication between the teacher and therapist is continuous during classroom activities and all during the classroom week. The child knows (and witnesses) that whatever he tells the teacher will be communicated to the therapist and that the therapist continually keeps the teacher informed of general trends of his work. All this is integral to the therapeutic work with the child. Some children find it easier to talk to the teacher rather than to the therapist. One little girl sat on one side of the teacher with the therapist on the other side of the teacher. She said, "Don't tell him about my dream last night," knowing full well that the therapist would hear this. She thereby used the teacher as an acceptable and receptive intermediary. Another child was very fearful of the therapist and of what the therapist was going to talk about (feelings about the loss of her mother), but could use the therapist's interpretations well while sitting on the teacher's lap during her session.

The teacher provides the child with a model for reception of deep communications by being reliable, accepting, and honest and by setting a climate conductive to expressive play communication. In order to set the stage for communication, it is the teacher's responsibility to create a climate which is straightforward and free from ambiguity. It is important for this reason to acknowledge absences of classmates or staff members. It is important to say hello or goodbye to anyone coming in and to clarify the purpose for the visit. Similarly, it is valuable in the specific treatment of a particular child to acknowledge child-perceivable realities around him, such as the child being able to see his mother's car parked outside the classroom window. Refraining from veiled in-classroom staff communications, and refraining from covertness in drop-off and pick-up time communications with parents helps model adult willingness to help children understand their perceived worlds.

The teacher encourages and supports the child's sublimations when the child draws a picture or involves him or herself in dramatic play. She shows genuine interest and thus helps to elicit the child's ideas. This type of education enhances the therapeutic process while making the child aware that self-expression and gathering knowledge is an important part of his life as well as important to therapeutic work. (Kliman and Ronald, 1970)

While the interpretive therapist spends only fifteen or twenty minutes with each child on a given day, the teacher usually remains in the classroom an entire school day. During sessions with consecutive index children, although the therapist maintains peripheral awareness of the other children, his or her primary focus prevents him from observing significant behavior and expressions of the other children, whom the teacher, meanwhile, continues to observe. Because a child's treatment session themes often continue to emerge throughout the school day, the therapist will miss a lot of first-hand experience of any given child's behavior and expression when not engaged in individual sessions. Continuations of expressions of therapeutic themes are commonly presented by all of the children in the classrooms after their sessions. The teacher performs the extremely valuable function of greatly prolonging professional observation of highly treatment related expressions by communicating to the therapist in their next briefing any significant behaviors and expressions from children which occurred when the therapist was absent or occupied with other children. The teacher's observation and reporting literally multiplies the duration of observation by a factor of at least two or threefold on a daily basis, certainly well beyond that of private psychotherapy sessions which usually last 50 minutes. This contribution from the teacher is an important factor in the child's progress towards recovery as her observations often provide the therapist

with rich material that is relevant to children's core issues and this material can confirm or help correct the therapist's interpretations.

Further, there is often a deepening of communication as the child's theme proceeds in expression during the class day. Children do more than express elaborations and derivatives of the same theme they communicated in the session. Greater frankness and consciousness of meaning is often developed by a child after a session. For example, a child who had been speaking in a symbolic way about masturbatory activity and castration anxiety with the classroom therapist proceeded an hour later to tell the teacher that he was worried about touching his own penis. He had earlier been unable to directly express this specific concern about his own body and had been doing so with the therapist in disguised ways involving buildings falling down and being broken by pinching lobsters. In that session, the teacher –having been made aware of the content of the psychotherapy session in a debriefing with the therapist immediately after the session– was able to communicate the material immediately to the therapist for his further understanding and future interpretation, (Kliman, 1970).

A method-specific collaboration between teacher and the interpretive therapist occurs in the treatment of intellectually inhibited children. Just as the therapist is interpretively releasing the child from inhibition, so that the child needn't release raw aggressive activity, the teacher may help the child to sublimate in a channeled way suitable to the individual needs of that child's newly available energy. An example involves the case of a child who was retarded to the point of seeming imbecility, but who responded to interpretations by showing marked eye contact and interest in other human beings. She began to scream for attention and became bullying. Teachers put this energy to work by utilizing her budding interest in the outer world, channeling it into creative and intellectual pursuits, particularly painting, storytelling and reading. The child became the best reader in her second grade class in a large metropolitan school system. Here the educational and interpretive processes had a clear synergistic effect. The therapist would have been handicapped in the interpretive process if he were simultaneously responsible for teaching the child to speak, read, and write. On the other hand, the teacher would have had no access to the necessary energies of the inhibited child were it not for the therapist's work with that child.

Because the teacher is constantly nearby during the child's interpretive therapy, she is able to observe and understand much of his play before and after the therapist's work with him. She can recognize many confirmative or responsive elaborations of particular interpretations through the child's play or words. She is usually far better able than the child's own parent to receive and communicate these observations succinctly to the therapist on the spot or before the next session. After the therapist leaves, the teacher often observes behavior that confirms or contradicts the therapist's interpretations. She is trained to always observe what the children do when the therapist leaves the classroom. In a traditional, pull-out analytic setting, a mother takes a child home at the end of fifty minutes (after an individual treatment) and there is scant opportunity to learn his reactions to interpretations or discussions. In Reflective Network Therapy, teachers have the opportunity to actually hear individual therapy sessions and make immediate follow up observations. The post-therapy themes are very often closely connected to the work that was done, so that there is a precise record of some of these confirmations and elaborations of themes or the continuity of theme, and the material is available daily, rather than during an occasional parent visit. The teacher becomes so attuned to the post-psychotherapy work that she or he is often useful to the therapist's memory and becomes an actively understanding observer of her or his work. Time and again the therapist is grateful to have the teacher pick up a lapse of his own observation, perception or memory. Equally, the therapist is very useful to the teacher in helping her to perceive herself and the way in which she works with the children, (Kliman and Ronald, 1970).

Thus, the teacher facilitates the child's work on clinical themes in a variety of ways, including her function as a stand-in observer for therapist while the therapist facilitates the child's ability to learn the curriculum as well as further cognitive development as a result of the therapy itself. We believe that the cumulative collaborative interplay inherent in the method is a factor in Cornerstone treatment outcomes showing surprising emotional as well as cognitive leaps over much shorter treatment periods, compared with our experience and data about other treatment methods such as ABA, (Sallows, 2005).

Therapists and teachers also collaborate to use simple criteria to monitor whether certain RNT processes are occurring as the method prescribes. Most commonly, there may be resistance to weekly parent guidance conferences. Monitoring that dimension has proven to be a supervisory necessity. Use of alternate means of network influence with parents can be helpful remedies or enhancements to regularly occurring parent guidance sessions; group meetings, and telephone contacts on an individual basis can be helpful. After hours meetings are often realistically essential. The collaborative benefits resulting from the parent guidance sessions are described above, including the high value of parent input and observations which influence both educational and therapeutic interactions with the child.

Expectations for Teacher Time Investment

Teachers should plan for at least two classroom hours a day with the children, at least two or three days a week and preferably a full five day school week. They should have coverage to allow an additional 90 minutes three times a week for parent conferences, team conferences, case related phone calls, and record-keeping. Classes which meet three mornings each week require 10.5 hours a week for the head teacher. Maximally, RNT classes convene five days a week with three hours in the class and 1.5 hours a day of other activities requiring 22 hours a week of the teacher's time. Teacher time spent on curriculum transmission will be planned to accommodate interruptions for individual child therapy sessions, to ensure participation in briefings and debriefings and to conduct weekly parent guidance sessions, except for once monthly when these sessions are replaced by parent conferences conducted by the therapist.

Coordinating Services and Sharing Information

Sometimes a child in RNT treatment on a part time basis is simultaneously enrolled in another educational program. When speech therapy is provided, we encourage this therapy to be given within RNT classroom and this is often practical for the provider. The teacher is the best person to coordinate schedules and communications with other educational or supplemental therapeutic programs.

Upon a child's graduation from RNT, the teacher and therapist together with parents should select what material is appropriate for transmission to later levels of service. Not all family material is appropriate for such transmission. A carefully selected compilation of material should be approved by the parent prior to transmission to public and/or private agencies. Control by parents over such transmission is best accomplished during parent conferences; parental signature(s) indicating approval of the documents and consent for transmission can also be obtained in this meeting.

Reflective Network Therapy: Costs and Staff Time

Reflective Network Therapy is less expensive than most other methods for a variety of reasons. Table 3.1 shows costs which result in an estimated annual savings of $23.000 per eight autistic children served by RNT rather than by ABA. For a large school system with 80 autistic preschoolers the savings would be $2,300,000 using the peer-inclusive RNT method instead of one aide per child.

Public Special Education programs in public schools or carried out elsewhere for public school children who cannot be served in mainstream settings are, by definition, supported entirely by the school district. Federal and state funding is potentially available to help local school districts with funding for children who qualify for I.D.E.A. (Individuals with Disability Education Act) resources.

Just as a portable oxygen tank might be necessary for a child to function in school, combining therapy with education may be both educationally and therapeutically necessary. Many children cannot be educated or reach their educational and developmental potential without special treatment. Reflective Network Therapy is well suited to fill that special need. Working within a public or private school or in collaboration with other preschool programs, RNT can successfully replace a public special education class. Alternatively, the method can be adapted to supplement an existing public school special education

program. As a supplemental program, Reflective Network Therapy can be incorporated either in the mornings or afternoons to provide treatment within the classroom. In other words, RNT can be managed as a full day or partial day program in any of these scenarios.

Upon graduation from RNT with a planned transition to another setting, there are very minimal short term additional costs associated with the need for an RNT teacher or therapist to make several visits to the new setting while the child is present. The RNT team member acts as an emotional bridge, much as parental participation assists with initial acclimation to the RNT setting. The new setting's teacher should also be invited (with parental permission) into an RNT team conference, once before and once after the transition is made.

Table 3.1 expresses the staff time required and the costs of enrichment of a public school special education system by the school adding a part time RNT service. This special program can be within an otherwise fully inclusive public school which has many preschool and kindergarten special education pupils. Eight children would be given half time enrichment through an on site Reflective Network Therapy service, as part of their parentally approved IEP's. The charted calculations of costs for use of teacher and therapist time in the RNT classroom are based on two and a half hours per day, five days a week for an educational therapeutic classroom operating under the auspices of a U.S. public school system or mental health agency. It is assumed that the classroom already exists, that a public school or public agency administration is in place, and that the children's families pay no treatment or tuition fees. No calculations are made for payroll taxes or other indirect costs. Before the first treatment year starts, several days should be set aside for staff training exercises.

RNT: TYPICAL STAFF TIME PER WEEK
AND RELATED COSTS FOR A 45 WEEK SCHOOL YEAR

HOUR PER WEEK FOR 8 CHILDREN, FIVE DAYS/WEEK	HOURS CLASS TIME	HOURS PARENT CONFERENCES	TEAM MEETINGS	HRS MISC	RECORD KEEPING	HOURS PER WEEK
Head Teacher Already in place at most special education services	31	6	1.5	0.5	1.0	**40**
Asst. Teacher Already in place at most special education services	38	0	1.5	0	0.5	**40**
Therapist	13	2	1.5	0	1.5	**18**
ANNUAL COST FOR RNT THERAPIST After the second year an RNT team with a licensed therapist can be self-supervising.						
If a therapist on staff is deployed for training and use in the RNT classroom			NO ADDITIONAL SALARY EXPENSE			
If a therapist is added to staff			ESTIMATED ANNUAL COST: $40,500			
Basic Costs for first year, second year and subsequent years: Training and Supervision						
START UP COSTS FIRST YEAR in a school or agency which already employs a suitable therapist who can be trained to perform RNT in the classroom			INITIAL INTENSIVE TRAINING, ONGOING TRAINING AND SUPERVISION IN RNT FOR THERAPIST AND TEACHERS			$20,000
SECOND YEAR			WITH REDUCED SUPERVISION			$10,000
SUBSEQUENT YEARS			SELF SUSTAINING: No Additional Costs			N/A
START UP COST PER CHILD:						
1) COST PER CHILD FIRST YEAR: IF A THERAPIST MUST BE HIRED						$ 7,562
2) COST PER CHILD FIRST YEAR: IF AN EXISTING THERAPIST IS TRAINED						$ 2,500

Table 3.1 Typical RNT Staff Time and Related Costs per 45 week full day full school year

When considering cost-effectiveness, we hope school and agency administrators study this chart which shows financial feasibility and provides motivation to use Reflective Network Therapy as an economy measure as well as an improvement in the lives of their pupils. This calculation employs an arbitrary figure for teachers' salaries which actually vary from community to community and from time to time, as do the conservatively stated salaries for ABA aides. Much of the ongoing cost of training of staff during the first year is incorporated into the weekly Team Conferences. Table 3.2 shows the overall cost advantage of using RNT in public school special education programs as opposed to the commonly used ABA supplement (Lovaas method).

COMPARING COSTS OF TWO EARLY INTERVENTION METHODS:
STAFF TIME AND SALARIES FOR SPECIAL EDUCATION ENHANCEMENTS

Enhancement for eight (8) difficult to educate children (ages two to seven) who have Serious Emotional Disturbances or Pervasive Developmental Disorders including Autism and Asperger's disorder.	
Method 1) ABA Applied Behavioral Analysis (Autistic and PDD children only)	Method 2) RNT Reflective Network Therapy (Autistic children, children with other forms of PDD, children with SED)
Requires a full time Aide for each child, added to existing special education classroom costs	Requires one in-classroom therapist added to existing special education classroom costs.
8 full time ABA Aides at the additional cost of 40,000 per Aide The children may be distributed among various special education classes or may all be in one larger class	50,000 for a half time RNT therapist The children may be distributed among various special education classes or may all be in one larger class
Total annual additional costs for 8 children's ABA aides = 320,000	Total annual additional costs for 8 children's RNT treatment = 50,000
TOTAL ANNUAL SAVINGS USING RNT RATHER THAN ABA Treating 8 children with RNT vs. using ABA: Savings = 270,000 Treating 80 children with RNT vs. using ABA: Savings = 2,700,000	

Table 3.2 Comparing Costs of Two Special Education Enhancements

Small Private Schools v. Public Schools as Sites for Reflective Network Therapy

A freestanding private therapeutic school is an expensive route, with costs similar to those incurred when using Lovaas one-on-one behavioral analysis aides. When a free-standing private preschool using only Reflective Network Therapy (which met California special education standards) was created, costs for the first year of operation were in the range of $250,000 per year for eight children (over $60,000 per child). That sum allowed for brick and mortar, utilities, insurance, administration, and full state special education certification as a California state certified nonpublic special education school. We didn't find the private school setting financially sustainable. We discontinued that effort and recommend a different approach: keeping costs down by partnering with existing mental health agencies. Such partnering is now occurring at The Ann Martin Agency, in Piedmont, CA, just east of our Agency's San Francisco headquarters and at Wellspring Family Services in Seattle. It can occur best through the addition of an RNT therapist to special education classes in existing preschools, (public or private) rather than through the creation of administratively independent RNT schools.

Application of Reflective Network Therapy makes the most fiscal sense in an existing public special education system or a community based mental health agency, where there is already brick, mortar, staff, administration, and a preschool or kindergarten population identified as in need. We demonstrated such projects were feasible in San Mateo and San Francisco Unified School Districts. All that was needed was to train and add a therapist! In one project we trained an existing school psychologist (already on staff) to conduct Reflective Network Therapy.

Emotional Recoveries and Intellectual Gains

Current scientific thinking related to the effectiveness of Reflective Network Therapy is explored and further developed in Chapter 10 of this book. Considering the years of unexpected successes with this treatment method, the emotional recoveries and intellectual gains experienced by a large proportion of child-patients certainly demand much further scrutiny for a satisfactory scientific explanation. Modern concepts of brain function (such as activation of the mirror neuron system) and connections between brain centers and hemispheres are literally in development and are important for us to bring into our studies. Today, functional MRI, PET scans, magnetoencephalographic studies and other new forms of brain imaging are possible. Beginning in 1996, we approached some families concerning MRI studies of their autistic children but were not encouraged by their initial response. We would like to try again. We have yet not had the opportunity to explore these lines of research with children treated with Reflective Network Therapy. We are focusing on what we have found by psychometric and clinical means and analyzing our procedures in an effort to isolate out what is necessary and efficacious. We look forward to various physiological and psychological multi-site random-assignment and controlled studies by others, independent researchers who can help point to fuller answers.

Love and Other Essential Conditions for Successful Treatment

We are in the midst of teasing out the factors which contribute to successful treatment in a very careful way by including blindly rated videotapes of RNT treatment sessions. We already have clues to what these factors might be. We believe the method's effectiveness has something to do with creating therapeutically designed social networks for groups of children which provide shared emotional and cognitive circumstances for the recapturing of the ability to love and to feel loved. Many of the children were lovable and loving when born and later became unresponsive to their families and to other treatments. Love, in this classroom method, is active in caring, tender, and nurturant in ways that are all too often left out of the equation or less fully employed in other methods.

Other therapies and education have often become overly sterile, even exclusively pharmaceutical and behavioral, or exclusively psychodynamic. Children are not merely a set of chemicals, habits, conflicts or symptoms to be metabolically altered, behaviorally retrained or psychoanalytically interpreted. Society –especially parents, caregivers and teachers of young children– can gain important psychological support, skills and wisdom by studying this method's network of reflective interaction and thought-encouraging, nurturant and caring treatment.

Roy N. Aruffo, MD, a senior child analyst from Houston, noted for his work with school consultation, made the following insightful comments in a personal communication to me after reading an early draft of *Reflective Network Therapy in the Preschool Classroom* in 2007. His words usefully restate the importance of appropriate love as used in Reflective Network Therapy:

The thrust of the whole method is to provide love (caring, tender, nurturant relationships) to children who born loving but who later became unresponsive to their parents. It creates "humane classroom networks, shared emotional and cognitive circumstances for the giving and recapturing of the ability to love." I think that this means understanding ways to love, ways that precisely fit the love needs of the child. Oedipal love is not of much use to an undifferentiated child who needs a large measure of one minded love in which the giver consciously and/or intuitively understands the helplessness and utter dependency of the child. The child must feel the fit between his needs and the giver's capacity to recognize and meet the needs. This means that the giver is of one-mind and one-feeling with the child.

I think that Reflective Network Therapy generates a more and more precise understanding of the child and the family through the continual family work and the discussions between the staff members. The parents too must be developing and restoring their capacity to understand the child. This thinking emphasizes the ego aspects (caregivers as auxiliary egos) of the giver-child relationship as opposed to the libidinal aspects – the love and nurturance. Caregivers must provide all the ego functions that the child has not yet acquired, judgment, memory, control of impulses, thinking, interpretation of sensation, tolerance of frustration, postponement of gratification, recognition of danger, etc. Without this the child is helpless in a hostile world and open to great pain. When the caregivers succeed the child seems to be calm, receptive of care, feels protected, safe, and connected. The child learns, is receptive to love and moves forward in its emotional development. When they fail enough the child withdraws, develops in an irregular fashion and becomes dysfunctional. This thinking puts one mindedness, one feelingness (empathy) as preconditions for growth. *–Roy N. Aruffo, MD*

Considering Aruffo concept, we can say that in the practice of RNT, we too often see children whose parents convey to the child an excessive sense of being alone rather than one with his parents. The child who needs oneness with the parent in order to feel secure and protected accepts the parent's distortions, is one minded in an unfortunate way with the parent, and applies the parent's distortion everywhere, including in school. Helping the parent see the distortions, even for a short period of time unleashes the child's pent up developmental thrust. We find that the most powerful growth effects of Reflective Network Therapy we have seen so far happen when:

1. A two-way transmission of observations and insights about the child occurs with each set of parents weekly; and

2. A psychodynamic therapist works in an RNT classroom four or five times a week.

Both of these factors have a direct statistical association with the IQ gains and clinical improvements (Zelman, 1985, 1996). We think each is probably essential in the network effect. Going further in our thinking about what is essential, we strongly suspect that missing any one of these or an even larger number of connecting links in the network among the team members, there is risk this method may not work so measurably well.

The clinical success of Reflective Network Therapy relies on the contribution of all these interacting factors: clinical evaluations, carefully getting to know the parents, parent involvement in the classrooms while children are and teachers are present, parent guidance, team conferences, briefings and debriefings before and after each child's daily fifteen to twenty minute session in the classroom, peer reflections on the child's treatment and behavior, high frequency of sessions, and long treatment duration. Similarly, without clear classroom instruction and modeling of empathy, without parental endorsement of the classroom rules, without boundaries of acceptable limits on child behavior, the children will not help each other.

Weekly all-staff conferences are essential for creating the network effect, and benefit from regular use of videotaped sessions as a focus for supervision. The study of videotapes helps ingrain mental representations of the children in the staff's minds. Since others may innovate and make changes or

deletions in the proven method, we urge that any innovations or subtractions from the above ingredients be recorded and reported to The Children's Psychological Health Center.

Getting Help: Starting a Reflective Network Therapy Group

As part of its mission, The Children's Psychological Health Center (CPHC) is actively engaged in providing assistance with wider use of the method and tracking results for ongoing scientific studies. It can contract to provide experienced RNT trainers, supervisors, and help a new site launch and carry out their program. We invite you to contact The Children's Psychological Health Center at www.childrenspsychological.org for training resources and supervisory support.

Use of the Terms: Reflective Network Therapy and Cornerstone Therapy

The term "reflective network therapy" has the purpose of distinguishing this psychosocial and psychoanalytic method from other efforts which may incorporate some of its techniques and processes but not all. As Reflective Network Therapy was first well known as The Cornerstone Therapeutic Preschool Method and referred to as Cornerstone Therapy or the Cornerstone method, we respectfully ask others not to call their work either "Cornerstone Therapy" or "Reflective Network Therapy" *unless* they use all of the method's component procedures as detailed in this manual, obtain basic training from certified, Reflective Network Therapy training supervisors, and operate under appropriate guidance. This will help avoid confusion as ongoing scientific studies of work using RNT techniques and service procedures go forward. If a team is borrowing bits and pieces of the method, in that case, please refer to the work by another name. Please keep us in touch with the results of your efforts so we can understand what might be the essential features of your successes and failures and help others learn from your innovations.

What Others Have Done You Can Do

Lest this technique might seem too difficult, or that only very highly trained or unusually talented people can make it work, an appendix (not comprehensive) identifies more than thirty persons who have actually used the method as the sole treatment modality in classrooms in several US states (New York, California, Washington, Massachusetts, Oklahoma) and Argentina. Over twenty others on the list were intellectual, supervisory, testing or scientific contributors or researchers. At least twenty teachers have done excellent RNT work not only without prior special education training but also without prior psychoanalytic experience, or therapeutic training. They did so mainly by working closely with their classroom therapists and receiving supervision from senior educators who had already learned the method. A marriage and family intern, Molly Franklin, MFTi, was very effective in the San Francisco private Cornerstone Therapeutic Preschool, using RNT with autistic as well as anxious and traumatized children. Similarly, Jane Christmas, PhD who was then a graduate psychology student, Miquela Diaz Hope, PhD, then a pre-licensure psychological assistant, and Linda Hirshfeld, PhD, also a pre-licensure psychological assistant at the time of her first involvement with RNT patients, all have very good clinical results. Peggy Herzog, PhD, who was at first a recently licensed psychologist, worked well with the method in Yonkers, New York.

Fran Morris Describes Applications of Reflective Network Therapy in Oklahoma

Fran Morris, MA, Clinical Professor of Psychiatry and Behavioral Sciences, University of Oklahoma Health Sciences Center, independently performed what we consider equivalent to RNT treatment for several years in Oklahoma City, Oklahoma. She emailed this follow-up which describes the duration of her experience with the method and also includes her notes on a follow-up on a patient after 18 years. The young man ("J.") had clinical and IQ gains that were sustained. Morris provided this report in a 2007 personal communication to Gilbert Kliman:

We started using this method in 1969 when analyst Marshall Schechter, MD established the first Diagnostic-Therapeutic Nursery at OUHSC as a part of our child psychiatry training program. Dr. Schechter had nurtured this idea since his visit to Anna Freud's Hampstead Nursery in England during his own training. The full-time program closed in 1984 but a Diagnostic Nursery continues (now only 1/2 day a week) as part of child psychiatry training, under the supervision of Povl W. Toussieng, M.D. (1984-1997) and James R. Allen, M.D. (1997-present). Dr. Toussieng and I passed on many of the basic concepts to Community Mental Health Centers in Oklahoma through a network of Therapeutic Nurseries that began in 1990 and built to 31 locations by 1996 but due to funding changes have now dwindled to almost none. There are still many clinicians in Oklahoma who are aware of Dr. Kliman's work. There is an active and growing Analytic Society here, and I still use a Cornerstone [RNT] video tape in some of the training I do for the state Department of Mental Health.

> J. came to our Diagnostic Nursery in February, 1978 at the age of four (DOB: 1-14-74). …the initial report found a severe speech/language delay, developmental delay in all areas except gross motor (which was considerably advanced), delayed emotional and psychological development and autistic defenses…I have a report from July 3, 1981 from Central State University that states that WISC-R scores were: Verbal scale 45, Performance scale 58, Full Scale 47. Next, I have a WISC-R dated March 20, 1982 that shows Verbal Score 67, Performance Score 81, and Full Scale 72. This was after he had been in our Therapeutic Nursery for 2 1/2 years. He was thereafter also in a special public school program for 1 and 1/2 years with me, where I provided once-a-week individual follow-up therapy.
>
> The initial diagnosis he was given at our Center was "Withdrawing Reaction of Childhood and Developmental Delays in Speech, Social and Psychosexual Development with Autistic Movements and Rituals. *–Fran Morris, MA*

Studying Dr. Morris' report, we note that, in infancy, the patient got a normal "Leiter IQ", using a test based on nonverbal tasks. For the present purpose, we are excluding that data, to use an "apples to apples" comparison approach to track the boy's overall IQ changes. We have created Table 3.3 to represent Professor Morris' findings, confined to the Wechsler IQ tests, since they are conservative about improvements with age, and comparable to each other. The findings she reports indicate a marked and sustained rise of Wechsler Full Scale IQ, a highly significant improvement which continued to increase for many years. It appears she kept this improvement going with a continued individual treatment relationship. Zelman (1999) has also reported that continuing psychotherapy adds power to the treatment. Strong IQ gains were made among preschool children who continued in treatment, within after-school groups conducted by Zelman on the Reflective Network Therapy model. (Similarly, Dorian Tenore-Bartilucci's continuously rising IQ was accompanied by several years of weekly psychotherapy after her Reflective Network Therapy.)

SUMMARY OF AN AUTISTIC CHILD'S IQ CHANGES: OKLAHOMA CASE

Oklahoma Case–Morris and Toussieng's Therapeutic Preschool Service

Test Type	Age	Year	Notes	Full Scale IQ
DOB Jan 14, 1974	0	1974		
WISC-R	4	1981	Severe autistic regression. Referred for treatment	47
WISC-R	5	1982	Marked IQ rise	72
WISC-R	6	1983	Continued IQ rise	91
WAIS-III	24	2001	Continued IQ rise	125

Table 3.3 Independent uses of techniques equivalent to Reflective Network Therapy included the remarkable case of a child who started treatment with an IQ of 47 and emerged with an IQ of 125.

Of the dozens of therapists listed as contributors to this method, only Kliman, Lopez, Balter, Rosenfield, Harrison, Henderson and Mallo have had full psychoanalytic training, and most had none at all. All, however, were supervised by dynamically knowledgeable and experienced RNT clinicians, most of whom had great interest in interpersonal therapies and the importance of human relationships in overcoming childhood disturbances of development.

Outcome Comparisons: RNT vs. ABA

Reflective Network Therapy's data base concerning twice-tested and closely followed children is still modest, like that of Applied Behavioral Analysis. Both methods have reported on similar numbers of children. The RNT data is much more comprehensive in important ways than the ABA findings, however. We have found only several dozen twice-tested among the ABA literature reports on IQ gains. Conclusions stemming from ABA baseline testing methods were scientifically flawed because they used developmental quotients for a first measure and IQ for follow-ups. Even an otherwise well designed effort retained this flaw (Sallows & Grauppner, 2005). As for functional recoveries and possible "cures", my RNT experience does not warrant a hard number. We await much more systematic data on failures and successes in both RNT and ABA methods. When pressed, Kliman estimates that 40 to 60% of the autism spectrum and pervasive developmental disorder preschool children he has known through Reflective Network Therapy services have gone on to be free of that diagnosis. That means that his thinking is that the remainder residual signs and symptoms enough to make the diagnosis after RNT treatment and schooling. If correct (and more funding, time and study is needed to verify that this is correct) then this success and failure rate is the same as the Applied Behavioral Analysis method. What is more certain is that the IQ gains in RNT treated children were better studied among properly comparable baseline and follow up tests; and, that the RNT IQ gains were at least as large as the ABA gains, occurred among even more children, and had almost no exceptions to the IQ gain effect among testable children

Reflective Network Therapy is clinical, by definition aimed at the mental health of seriously emotionally disordered children, autistic children and/or children with other pervasive developmental disorders. ABA does not generally define itself as a mental health technique, and probably for that reason has not measured the overall mental health effects on autistic or other children.

Categories of Children Well Served by Reflective Network Therapy and other Considerations

Regarding the diagnostic categories of children who can usually be well served by Reflective Network Therapy, over the past four decades the method's combination of education and therapy has resulted in substantial clinical and cognitive progress among children suffering from:

- **Adjustment reaction disorders, such as reactions to sexual molestation, foster care placements, and domestic violence**
- **Asperger's Syndrome, including Asperger's children with overly aggressive behavior**
- **Attention deficit disorders, with and without hyperactivity**
- **Autism spectrum disorders (ASD)**
- **Behavior disorders**
- **Combinations of developmental and emotional disorders**
- **Combinations of overanxious and aggressive behaviors**
- **Conduct disorders**
- **Depressive disorders**
- **Early childhood depression**
- **Early childhood psychoses**
- **Elective and selective mutism**
- **Emotional effects of life-threatening illnesses in the child or close relative**
- **Oppositional defiant disorders**
- **Overanxious disorders of childhood**

- **Parent-child relationship problems**
- **Pathological bereavement reactions**
- **Pervasive developmental disorder (PDD)**
- **Physical disorders that are worsened by emotional stress, such as psychogenic aggravation of asthma**
- **Posttraumatic stress disorder (PTSD)**
- **Reactive attachment disorders**
- **School phobia**
- **Social phobia**
- **Traumatized children**
- **Children with multiple diagnoses**

Although Reflective Network Therapy clearly helps children in many diagnostic categories, our studies to date are statistically weighted for two categories: preschoolers who are either autistic or traumatized. Detections of these same two categories of early childhood disorders (autism and posttraumatic disorders) are probably on the increase in the general population as well as among children referred to RNT services. Current estimates of the general population incidence of autism are 1 in 150. This number may even be low due to underreporting and inconsistencies in screening practices. Reported cases of early childhood forms of autism have risen at a startling rate in the US, Europe and Asia (Cunningham, 2006). No one is sure yet whether autistic children are being more effectively identified or whether little-understood genetic and environmental factors are at fault for their reported numbers increasing.

There is no clear and persuasive scientific understanding or consensus of investigators about causal factors in this increase, although certainly, autism is a disorder with a basis in brain and genetic abnormalities. Functional MRI studies (Just et al., 2004, 2007) show many well-functioning parts of autistic children's brains but a lack of their connections via white matter. Children with autism can be rehabilitated through cognitive, or emotional and social exercises (Sallows, 2005; Hope, 1999) which from our point of view may have their good effects by exercising and enhancing networks of neurons and neuronal connections.

There are very widely differing sets of brain and interpersonal problems addressed in child psychiatric treatments of children with the disorders we listed above. The problems of emotionally disordered children with attention deficits, hyperactivity, anxiety disorders, depression, post-traumatic disorders or oppositional-defiant behavior are very different from the problems of children with autism, Asperger's Syndrome, or other forms of PDD. Foster children have additional special needs, tending to suffer prior neglect and abuse, followed by discontinuities of care partly brought about by their own posttraumatic behaviors (Kliman and Schaeffer, 1990.) It is probably not a coincidence that traumatized children respond particularly well to the reflective network of "Cornerstone" therapy (Zelman, 1996). Unlike other therapies, Reflective Network Therapy is particularly well suited to and can be easily individualized for children suffering from all the pathologies listed above and can be delivered in an inclusive classroom. A contributing factor to the method's success is its corrective exercise approach to a factor common to all of the listed disorders: resistance to loving and learning in small social networks.

The All In One Classroom

Few child psychotherapies or educational methods have documented that they can be tailored enough to help children with such widely varying problems, especially in the same classroom or group. Reflective Network Therapy's interdisciplinary combination can be reliably tailored to be inclusive and to help very different kinds of special needs children with emotional or developmental problems in the same classroom. It also works well with the social adaptive problems of children overwhelmed by or coping poorly with the loss of a parent or placement in foster care and with children suffering from posttraumatic stress disorder. The inclusion of children suffering object loss who may not be developmentally delayed is good for all the children. It promotes healthy empathy and altruism among the more advanced children,

and gives an opportunity for the less socially advanced children to develop further. The more advanced children perform the function of “expert players.” (Wolfberg, 2003)

Few child psychotherapies are versatile regarding the settings within which they can be carried out. Using Reflective Network Therapy, an agency with a therapy group, a private preschool group, or any public special education class serving multiple diagnostic categories of children can be the arena for helpful treatment and sometimes even recovery. Head Start programs, shelters for homeless families or recently homeless families in transitional housing, and private day care centers have all found the method feasible and effective, and it is in use within a regular private preschool.

Still fewer child psychotherapies or educational methods have documented that they substantially raise objectively measured intelligence quotients (Heinicke, 1966; Lovaas, 1987). RNT’s in-classroom educational and psychotherapy does raise intelligence quotients, substantially and reliably.

Reflective Network Therapy offers new hope to several sets of parents. The first set is parents of emotionally disturbed children–including traumatized children or those with anxiety disorders, oppositionalism or attentional difficulties. The method offers special hope for such children. The hope comes at a time when prolonged chemical psychiatric treatments with medication may be helpful but (in the cases of Ritalin, Risperdal and Clozapine, for example) sometimes dangerous for preschool children with such emotional disturbances (Lagace, Noonan, and Eisch, 2007).

The second set of parents (growing in number) is those whose children have pervasive developmental disorders, including the autism spectrum, Asperger’s Syndrome and full-blown autistic disorders. Expressive and receptive language problems are a regular part of pervasive developmental disorders. So are interpersonal avoidance, oddities of play, stereotypic movements, and hypersensitivity to sound and touch. In moderate to severe cases the children lack a loving interest in human beings. They have little empathy, understanding or theory of the mind of others. Many children with these disorders live and go to school in their communities, but often only with great distress and high economic cost to their families and taxpayers. For this set of parents, the publication of this book comes when the best known and most widely used behavioral method, Applied Behavioral Analysis (ABA) or Lovaas method is also showing cognitive benefits (Eikeseth 2007), though its findings based on shaky science and requires thousands of hours of treatment. These benefits include IQ gains similar to those achieved using RNT but the ABA has major relative drawbacks. The Lovaas method is, in our opinion coming close to being scientifically sound (except in its choice of baseline measures to compare with later measures) and is probably effective but is not clinically versatile. It is much more expensive than Reflective Network Therapy, requires thousands more hours per year for similar IQ gains, does not use trained psychotherapists, is deliberately less ambitious in its goals about personality growth among autistic children, and is less clinically documented and studied than what the reader will find here. Taxpayers and school administrators will be surprised at the large cost-benefit which can come from using the less expensive RNT method for autistic children, in comparison with the more customary and more expensive ABA approach. Chapter 9 of this book provides a fuller discussion of the advantages of Reflective Network Therapy in terms of cost-benefit analyses.

The third set of parents who are helped by Reflective Network Therapy is those who care for foster children. Youngsters who are placed in foster care because of neglect or abuse or the death of a parent or primary caregiver are numerous, and those children are likely to have a posttraumatic reenactment tendency to provoke further rejection, abuse or abandonment. Their placements with foster families often fail because of child behaviors which are well calculated to provoke or test the possibility of new rejections (bouncing). In a controlled study, we found that about 25% of first placement foster children bounce from foster home to home during their first year. Bouncing is known to be one of the most psychologically malignant experiences for foster children (Pardeck, 1983, 1984; Kliman, 2006). Not one of the thirty foster consecutive children treated by Reflective Network Therapy method bounced during the study year (Schaeffer and Kliman, 1990; Kliman, 1987, 2006).

Overcoming Resistance to Learning

As mentioned earlier, soon after the method was applied to treat bereaved preschoolers, the method was discovered to help many young children cognitively as well as emotionally. Countless disturbed preschool children profoundly resist their caregivers' loving efforts. They stop receiving constructive knowledge from their teachers, parents, and peers; they become unreceptive to learning. The following pages have been inspired by the opposite experience, the opening of tightly closed hearts and minds.

In keeping with the appropriateness of still wider use of Reflective Network Therapy, and since the method requires the participation of parents, this book is written in a style intended to introduce the method to parents as well as teachers and therapists. Public education of parents about the method has already begun, with the help of television news broadcasts. In late 2004, an eight-year-old Bay Area boy and his father were interviewed by John Fowler (KTVU channel 2 Health and Science news editor and reporter) in an evening news feature. Viewers could see that the formerly retarded, odd seeming and withdrawn boy was in a happy relationship with his father, attending a regular, mainstream school, sociably joking and laughing, looking the reporter in the eye, reading math homework aloud and figuring it out correctly in the midst of distractions.

What was newsworthy enough for the eight year old and his father to be interviewed on TV? At the time, California was experiencing the first reports of an epidemic of children with developmental delays, especially with autistic features. Three years earlier, the now vivacious and humorous child had been a developmental wreck. A school psychologist, pediatrician and a child psychiatrist had all diagnosed him as mentally retarded and autistic. Only six months before the TV broadcast, this boy had barely been able to take the math section of the IQ test with a very experienced University of California developmental psychologist. Yet, as documented by Fowler's broadcast, he no longer seemed autistic or retarded. His IQ had risen from a retarded level at the first testing to normal at a second testing two years later. The TV segment documented his continued growth in math, which had become a source of pride for the child and his family. What caused this life changing turnaround in this boy's condition? He had received two years of Reflective Network Therapy, beginning at age four years. The previously restrained forces of his development, which had literally retarded him mentally, had been unchained by that therapy. Within two years, the socially isolated, screaming, oppositional, angry, grim, and socially withdrawn, seemingly very dull boy had become loving, humorous and bright. A year after he left Cornerstone, he was in regular public school classes, doing reasonably good work and behaving well.

Can This Method Be Carried Out in the Home?

We have been asked whether this method might be adapted for primary caregivers and families to carry out. Although any arrangement which sacrifices key elements of the method should not be expected to yield the same clinical results as a full application of Reflective Network Therapy in a classroom, families with resources and substantial guidance may be able to use the method to advantage. Some parents have actually done so by establishing reflective networks on their own, after prior personal treatment experience as children in RNT treatment. We need to follow such experiences more rigorously.

Christina Adams describes her adaptation of "Cornerstone" [RNT] to her son's multiple needs (Adams, 2005). She and her boy, Jonah, received some modeling in Reflective Network Therapy techniques from us at a Cornerstone preschool and directly from me as a visitor in her own home. The family was very successful with their distinctly autistic boy, and five years later she was able to report that Jonah appeared vivacious, humorous, possessed of a good theory of other minds and was well recovered and well developed. Kliman was impressed with how Ms. Adams went about using the method's briefing and debriefing techniques, creating a reflective network team by including speech and occupational therapists involved with her son. Her autobiographical book (Adams, 2005) deserves considerable research planning. We would like to see a test of feasibility, using Reflective Network Therapy at home, orchestrated by children's therapists and parents in a significant number of families, with tracking of cognitive and mental health gains using standardized initial and follow up testing. That project could be conceptualized as having many delivery advantages, particularly before a child is old

enough or competent enough to be attending a group setting. Dorian Tenore-Bartilucci's account (How I Recovered from Autism) also includes mention of doing "Cornerstone" work later in life with her own autistic daughter. Tenore-Bartilucci and the Adams parents recruited small networks to help their own autistic children. These important private home and family projects require another set of studies and essays to do justice to the potentialities of harnessing reflective networks in systematic ways.

Finally, we want to welcome you as new users of Reflective Network Therapy, and hope you find this manual useful in your everyday therapeutic and educational work! Please stay in touch to better help others in need.