

Methods for Maximizing Good Effects of Foster Care: Evidence-Based Strategies to Prevent Discontinuities of Foster Care and Raise IQ

GILBERT KLIMAN

ABSTRACT

What can psychoanalysts do to prevent transmission of trauma? One way is to improve the lot of children whose fate is in the hands of society, particularly those in foster care. The repetition compulsion is a psychoanalytic hypothesis which predicts that foster children carry within them behavioral memories of being rejected, neglected, or harmed by their families of origin. Children's enactments of these memories dispose their foster families to recreate the events, reject the troubled children, and produce further traumatic discontinuities of care. This psychoanalytic concept can be operationalized within social service systems. An aspect of repetition compulsion of foster children is measurable by tracking the number of transfers between foster homes. The phenomenon can be substantially reduced by focused psychoanalytically oriented psychotherapy of the children and their caregivers (Kliman, 1996). Remarkably, there is statistically significant evidence that children's IQ are enhanced by a certain form of intensive psychoanalytic psychotherapy in the preschool years (Kliman, 1968, 1970, 1997; Zelman and Samuels, 1996; Hope, 1999). Copyright © 2006 John Wiley & Sons, Ltd.

Key words: foster child, transfers, IQ, psychotherapy, network

INTRODUCTION

The author and other researchers find that foster care is a behaviorally and cognitively growth-promoting experience for most foster children (Fanshel and

Shinn, 1978; Freeman et al., 1928; Kliman et al., 1982). The experience of foster care with a subset of intellectually stimulating or democratically permissive families, children's IQ can be raised significantly (Fanshel and Shinn, 1978; Freeman et al., 1928; Kliman et al., 1982). Wide Range Achievement Test scores also rise among foster children (Kliman et al., 1982). But as the Stanford-based review of Wald's (1985) and that of our own team have emphasized (Pardeck, 1983, 1984; Kliman et al., 1982) the opposite fate is more often true. Data show the discontinuities that often develop in foster care create a cycle of noxious experiences for a subset of vulnerable children who "bounce" or transfer rapidly between foster homes.

Sadly, in a blatant and socially ignored way, "bouncing" and its associated career of deterioration in foster care is foreseeable. Giving a basis for prediction was a statistically significant finding of our population-based research, in which we gave psychiatric evaluations to 96 unselected children entering foster care for the first time. We showed (Kliman and Schaeffer, 1990) that children with any DSM III or DSM IV diagnosis other than adjustment reaction disorder will bounce between foster homes more than other children. The most disturbed and vulnerable children (those who most need stable human relationships) were the most likely to bounce from home to home.

Though an effort to make an intake psychiatric diagnosis of foster children is not reliably built into social service systems that we know, the diagnosis of a childhood psychiatric disorder is a unique preventive opportunity. Psychiatric diagnosis (except adjustment reaction disorder) is a simple and low-cost predictor of future harmful social system experience: bouncing and its high-cost aftermath. This preventive study logic has a foundation as follows. Kliman and Schaeffer (1990) showed that the presence of a psychiatric diagnosis predicts bouncing. Several other studies show that multiple bouncing predicts bad later-life outcomes.

The number of children in foster care in the USA increased by 65% in a recent 10-year period (Clay, 1998), and there were 462 000 US foster children by the end of that epoch (Barbell, 1997). At the same time, one of the most malignant aspects of foster care – discontinuity of human relationships – has also been increasing. The most vulnerable children, those with diagnosable developmental delays and behavior disturbances, have the longest stays and the most multiple placements (Horowitz et al., 1994). Between 1984 and 1986 the average number of placements per child rose by 15%, to 2.9 per child.

Malignant aspects of multiple placements in foster care are numerous: running away from care; spirals of adolescent sociopathy; poor economic outcomes; low marital stability; and ultimately a cycle of adult former foster children's homelessness and placement of their own children in foster care (Zimmerman, 1982; Festinger, 1983). Runaway status and, as an outcome, homelessness during childhood appears a highly specific phenomenon among foster children. Shaffer and Caton (1984) showed that use of shelters for runaway children by former foster children was very common. Shaffer and Caton (1984) found that among young-

sters using such shelters the foster children were nearly a majority, as well as far and away the most seriously disturbed and the most serious danger to themselves and others. Follow-ups by Zimmerman (1982) indicate an orderly correlation between criminality and number of homes, and that the most violent felons among former foster children when grown up are those who had the largest number of homes. Thus, common among these malignant features and statistical associations are relational discontinuities, which this paper indicates are preventable.

The present essay flows from our previous projects, each one including an effort to deal with the mental health problems of children in foster care. In particular, we have been trying to increase children's assets via cognitive gains as well as via behavioral improvements, and always specially trying to reduce the discontinuities of foster care. In that process, our research has shown the following seldom-credited benefits social service systems provide to foster children (Kliman et al., 1982; Kliman and Schaeffer, 1990). Foster care – even without any therapy added – is often cognitively and behaviorally beneficial. We found that among our samples of foster children in New York State (Kliman et al., 1982) the Wide Range Achievement scores of children who remained in foster care were higher than those of children who return to their biological families. Similarly, indicators of emotional problems (Koppitz scores) are less disturbed among children in foster family care than among those same children who return to their biological families. Our data among the unselected, consecutively placed 96 foster children showed that intellectually stimulating and democratically permissive foster parents produce a four-point IQ gain among their foster children.

It seems self-evident that the problem of discontinuity within care is a severe stressor to foster children. Having already had an attachment discontinuity caused by their foster placement, they literally bounce from home to home just at a point in life when compensatory continuity is needed. The placement of a disturbed child in a therapeutic foster home definitely helps to reduce bouncing (Reddy and Pfeiffer, 1997). During the much more common non-therapeutic foster family care placement, bouncing can also be markedly reduced by two preventive therapies we have designed, described below.

The projects we have mounted and helped others to carry out (Bondy et al., 1990) using our methods have been collaborations with departments of social services and private agencies. Our results have involved about 1900 children. The author therefore appeals to individual psychoanalysts, administrators, caseworkers, clinicians, and foster parents to remedy and even prevent the bouncing that public social service foster care systems may otherwise tolerate or ignore. Thus, we describe what we have created for such agencies and individuals to use: individual, family, and small-group therapeutic modalities, designed to help make foster care a continuous placement experience, with human relational continuity as its backbone. Two of the most promising of those modalities are presented in detail here.

THE PERSONAL LIFE HISTORY BOOK

The Personal Life History Book (PLHB) method, as written by Kliman (1987) for psychotherapy with children in foster care, has been used by members of several professional disciplines working with the children: social workers; psychiatrists; psychologists; psychotherapists; and foster parents. The advantage of the therapeutic use of the PLHB is not only clinical but also social, including the decrease in multiple placements. The PLHB can be used by foster parents with their foster children in private foster homes, group homes, and facilities. It can be used with one child at a time, or with a sibling. It can be the main basis for a group therapy, and we have helped one agency – the Jamaica Child Guidance Center, of Queens, NY – to develop its use in groups of up to 16 children at a time (Bondy et al., 1990).

Basics of the PLHB

Foster parents, the child, often the biological parents, and a therapist work once or twice a week for 30 private sessions to complete a PLHB for each child. During most of the 30 hours assigned to each family the child and therapist talk in private about the child's history, fill in the book, talk about memories and current experiences, and make drawings about the past and present. The PLHB has many sections. The child and therapist assemble – with the help of foster and biological parents, siblings, and other extended family – albums of pictures, report cards, and make address books of people to write to, lists of people who can chat with the child on the telephone, and the birthdays of important people to whom the child could send cards. There is a section on medical and dental history, and a place for report cards. Detailed instructions about giving the child choices in use of the manual, tact concerning a child's resistances, caregiver honesty, and preparations for termination of the work are the substance of the manual. Extensive PLHB case examples have been published (Kliman, 1987, 1996).

The PLHB was first written by Kliman (1987), at Columbia University. The method had previously been independently conceived and used as a therapy by Aust (1981) with foster children, but replicability of method and assessment of outcome by objective means was lacking. Kliman's Foster Care Study Unit, at the Columbia University Department of Child Psychiatry achieved replicability through creation of a manual, and, in the same project assessment, via a complex selection of subjects and controls. A set of training DVD's for professionals has been produced (Kliman, 2004).

Design of an Experimental Project

Beginning with a population of 648 foster children consecutively entering New York City foster care in five different agencies, 52 children were selected by criteria of age, sex, and race, and were placed into PLHB and control groups. Among the 52 children were 16 extremely closely similar matched pairs of sub-

jects: eight control subjects and eight treated with the PLHB. The matched pairs had been subjected to sorting by the additional criteria of greatest closeness in sex, age, race, and child behavior checklist scores. Having found highly comparable control and PLHB subjects, we proceeded to give a 30-hour program of writing a child's personal life history book to 26 of the 52 children.

Results

A highly significant ($p < .001$) advantage in reducing transfers between foster homes was noted for PLHB use among the matched pairs. An odds analysis was made. The odds of a PLHB-treated child having a "bounce" in foster care were reduced 11-fold compared with the matched pair control child.

Further Study

The initial transfer or bounce-reduction effect with individual foster children was so marked that we agreed to help the Queens Child Guidance Center to use the method in a more diluted way with groups of 6–16 foster children. Treating more than 200 children in such groups, the Queens' agency found the method feasible, and showed a distinct reduction of transfers between foster homes compared with the untreated general population of New York City foster children (Bondy et al., 1990). Having also used the method in private practice and through several agencies in California (St Mary's Hospital, San Francisco; Kern Bridges Youth Home, Bakersfield; Children's Garden, San Rafael), we now recommend it as a low-cost, practical way to reduce transfers between foster homes.

THE CORNERSTONE METHOD: APPLICATION OF PSYCHOTHERAPY IN PRESCHOOL TREATMENT GROUPS

This method involves the treatment of stressed children, such as those entering foster care, or emotionally disturbed children entirely within their preschool and day care groups. We and our associates have treated dozens of foster children this way, among more than 800 preschool disturbed children treated. As previously reported, bouncing is sharply reduced among foster children receiving this treatment: down to zero in the first 12 months in our pilot studies (Kliman et al., 1982). Equally engaging to us is the presence of regular and substantial IQ gains among children treated with the Cornerstone method (Lopez and Kliman, 1979; Zelman et al., 1985; Zelman and Samuels, 1996).

We have tested the feasibility of using an intensive Cornerstone Method psychotherapy as a pilot study in a public school special education setting. One purpose was to determine broader feasibility and acceptability as well as outcomes. Nineteen therapists in the nation have carried out this method with more than 900 children for over 30 years. But, until recently, the bulk of Cornerstone work has been in mental health centers, within therapeutic nursery classes filled with patients referred by other clinicians for treatment.

Parents in a public school special education setting were offered the option to enrich their disturbed preschoolers' special education with this mental health service. Six of 30 consecutive children selected were foster children. As part of the public sphere testing, the author was in the public school classroom, as a therapist, using the method in San Mateo, California. Providing treatment for entire classes of disturbed preschoolers within the San Mateo public preschool special education classes, Kliman supervised other therapists using the method in the San Mateo public special education preschool. It has also been feasible to apply the method by supervising psychology interns with preschoolers at a transitional living shelter for homeless families.

As a result of several hundred hours of videotaping, we now have three instructional DVD's available (Kliman et al., 1998), which include documentation of the method's techniques and its applicability in a public school setting. The DVD's show substantial improvement of a four-year-old with Asperger syndrome with prominent autistic and psychotic features, a former foster child with post-traumatic stress disorder, and a child with overanxious disorder. The child with Asperger syndrome, who was untreatable in other settings: wild, masturbating, throwing furniture, and striking others. Nevertheless, the child improves and actually develops empathic sociability. A tape concerning the treatment of homeless preschool children is in preparation (Kliman and Vigilante, in preparation) and this has special relevance because of the close connections between a history of foster placement and homelessness.

Unique Features of the Cornerstone Method

- The therapeutic process has primary focus on classroom behavior and communication: the modality is here-and-now based. Though it is derived psychoanalytically, it differs markedly from a classical psychoanalytic approach because it occurs in the real-life space of the child, taking place in a classroom the child would be attending whether or not the mental health services were provided. It is oriented to the young child's immediate troubles, worries, conflicts, deficits, ambitions, loves, hates, adventures, and achievements as reflected in a classroom. It primarily relies on interactional, dynamic, or cognitive techniques rather than chemical or primarily behavioral interventions. Therapy thus relates mainly to what behavior occurs in the child's life within the classroom, in response to classroom events, or to family or other events that may have just preceded entry in to the classroom. In psychoanalytic hands, this behavior may be used interpretively, and then can be used to bring the child in touch with past experiences that control present behavior.
- The site for the child's treatment is exclusively the classroom itself. Regardless of orientation, the psychotherapist works with the child only within the special education classroom or day care group. He works with each child individually and consecutively in a set sequence. Seven to 12 children are

treated this way in the midst of each classroom's regular activities, with the help of two or three teachers. The therapist works for 15–20 minutes at a time with each child in the classroom each day, five days a week, all of the school year. Classes meet every weekday, for 20 or more hours each week. The therapist's time in the classroom is usually two hours per day per seven children, three to five days a week. The psychotherapy is based on the particular psychotherapist's highest level of training, which is preferably psychodynamic. Successful psychotherapy can also be carried out this way by psychiatrists, social workers, and, in good circumstances, by inexperienced therapists such as psychology interns, when well supervised. This model of supervised therapy conducted by an intern has been carried out now at the Union Baptist Day Care Center in Greenburgh, NY and the Salvation Army shelter for homeless families with preschoolers, San Francisco Gateway facility and the Ann Martin Center in Piedmont, CA.

- Use of a team with distinct roles for the members: The roles of teachers and psychotherapists are completely different in the classroom, but the interplay of the two disciplines is critical to the success of the work. The Cornerstone teachers deliberately refrain from making interpretations. They do no psychodynamic work. They facilitate the child's management of impulses which may be released by the therapy, and encourage the child to be curious and creative. The therapist stays in the role of forming a personal therapeutic relationship with the child, whereby the child is encouraged to mentalize rather than simply act, understand, and express feelings, to gain mastery around traumatic experiences, and to free energy for learning tasks.
- Structured communications in the classroom help to create a network of cognitive and emotional support: Briefings and debriefings occur systematically. Immediately before the therapist starts a session, teachers give the therapist and child a one or two minute summary "out loud" of the child's recent behavior and play, so the child and therapist have the advantage of their current observations. A concerned, neutral, and mentalizing example is thus conveyed. Sometimes this is the first time in a child's life a constructive team has worked with him. Role modeling of acceptance and encouragement for progress occurs without humiliating the child. After each treatment session, a debriefing is made by the therapist and child to the teacher, or by the therapist while the child listens. This debriefing enables the child and teachers to continue the themes of treatment work after the child's individual 15-minute psychotherapy session ends.
- Parent guidance is intensive and given mainly by educators: the therapist meets once a month with each parent. The teachers meet once a week with at least one of the child's parents or foster parents. The teachers' interactions with the parents are supervised by the same therapist who treats the classroom full of patients.

Results

Recently, 14 of 20 eligible families with preschoolers in special education public school classes and seven of 10 families in a homeless shelter accepted the opportunity for Cornerstone treatment of their preschoolers. Previous studies show clinical gains are substantial across a wide range of clinical conditions. Results are highly significant clinically (in terms of GAF improvement) and cognitively (in terms of IQ gain) among mildly to moderately traumatized children, three- and four-year-olds (rather than five-year-olds), and especially among those who attend many treatment sessions and have many parent guidance meetings. IQ testing and retesting of 50 preschool Cornerstone patients treated in a community mental health center and followed for at least one year show the average Cornerstone child has a rise of 12 points, whereas 10 long-term preschool patients at the same center treated intensively by other methods did not have an IQ rise (Zelman and Samuels, 1996).

Case Example

Henry, aged three and a quarter when he entered Cornerstone in our White Plains, New York Cornerstone facility, was an African American boy referred by the Department of Social Services. He had been in foster care for six months and already was in his third home. Henry's mother was in a drug rehabilitation center and saw him for an hour a week, and his father was serving penitentiary time for sale of heroin. In his two prior foster homes, Henry's cries of lonely protest and his sobs of despair, his bed-wetting and property damage had precipitated the foster parents' unplanned termination of the arrangement: they literally requested that he be removed. In a day care and then a Headstart program, Henry's biting and kicking of other children, and his assaults on teachers with blocks and toys, ended his stays. Cornerstone seemed a last resort to Henry's caseworker, and she arranged for him to be transported daily to our in-classroom therapy program, where he spent 15 hours a week. His foster mother came regularly for guidance, which was mainly a weekly mutual sharing of events with Henry's teachers.

Cornerstone work started with a bang for Henry, as he threw a wooden block at a window. Fortunately, it was a plexiglass window, made for the purpose of invulnerability to such assaults. His play focus soon gravitated to other children, with whom he wanted to cook. He usually wanted to be "daddy" and over the next weeks showed many nurturant and hygienic interests in baby dolls. Henry created a wide variety of soups for them to drink and bathed them rigorously but tenderly. His angry spells grew fewer, and, as analyst in the classroom, Kliman interpreted some of them as his way of showing he missed being cared for. His great tenderness to dolls was later interpreted as showing what was on his mind – how nice it is when a Daddy loves and takes care of a child. Henry had brief outbursts when this line of interpretation evolved, but grew closer to

Kliman, developing a clearly paternal transference. Kliman responded with muted but heartfelt tenderness of his own toward Henry. Toward the teachers Henry had similar apparently maternal transferences, and they responded in kind, often helping him with toileting. He rapidly achieved full day and night training for bowels and bladder. His clarity of articulation, vocabulary, and length of speech production grew far more than the passage of time would lead us to expect. Property damage ceased in the foster home. The foster parents reported a growing tenderness of their own toward Henry, and sympathy for the parents. In class there was much working through of his historical disappointments in his parents, his anxieties about the health of his foster mother, and his memories of his parents injecting themselves with heroin. Many features of a psychoanalytic psychotherapy were observable, including the following:

- increasing thematic continuity of play and communication
- rise of ego function level following interpretations
- production of relevant historical material in response to interpretations
- continuously more elaborate communication over time
- insight concerning his regressive and aggressive behavior, including protests and pleas for nurture
- increased understanding of the mental lives of others
- transformation of behavioral symptoms into dialogue and play.

Henry's IQ rose 14 points in his year and a half of Cornerstone treatment. His foster placement never changed. Follow-up five years later showed Henry living with his mother and a stepfather, functioning well socially and academically. He displayed no antisocial behavior.

DATA CONCERNING GLOBAL CLINICAL ASSESSMENTS AND COGNITIVE CHANGES IN RESPONSE TO CORNERSTONE THERAPY AND OTHER THERAPIES

We have been able to study the cognitive effects of Cornerstone therapy with 53 treated preschoolers who were tested twice. Forty-two of those subjects were located through archival studies. To avoid a self-selecting effect among twice-tested children, we mounted a study of 10 consecutively referred children in a public school Cornerstone project. These preschoolers were seriously emotionally disturbed, consecutively referred, and consecutively treated within a public school early childhood special education center where we placed a Cornerstone therapist. We had a control series of six similar preschoolers in a nearby early childhood special education class. Three other preschoolers were given a comparison treatment in a homeless shelter, a supportive–expressive therapy with no interpretations. The results of the 53 Cornerstone-treated and twice-tested children, six control subjects, and 109 comparison-treated young children were

highly significant for an advantage to Cornerstone therapy outcomes in the Children's Global Assessment and Wechsler Preschool and Primary Scale of Intelligence – Revised (WPPSI-R) IQ. A meta-analysis of the projects appears below.

IQ Change by Treatment Modality Data and Graph

Tables 1 and 2 show Cornerstone therapy compared to control and comparison treatment modalities toward a meta-analysis of IQ change in Cornerstone therapy versus other interventions. The total number of subjects was 115.

Distinctions and Commonalities in the Cornerstone Method and PLHB Method

Both the PLHB method and the Cornerstone method are effective in reducing transfers between foster homes. So far, the PLHB has not been studied for IQ outcomes, although other comparison studies have contained that feature. The

Table 1: Cornerstone-treated children

| <i>Modes and subjects</i> | <i>IQ change</i> | <i>Number</i> |
|------------------------------------------------|------------------|---------------|
| 1965–1978 NY Cornerstone Preschool, 2–5/wk | 12 | 42 |
| 1996–1997 CA Cornerstone Public Preschool 2/wk | 13 | 6 |
| 1995–1996 CA Cornerstone Public Preschool 4/wk | 28 | 4 |
| 1965–1985 NY Cornerstone 5/wk | 28 | 10 |
| Pooled NY and CA 4/wk and 5/wk Cornerstone | 28 | 14 |
| Pooled NY and CA 2–5/wk Cornerstone Patients | 14 | 52 |

Total number of Cornerstone-treated children = 52.

Table 2: Control and comparison-treated children

| <i>Modes and subjects</i> | <i>IQ change</i> | <i>Number</i> |
|------------------------------------------------------------------------------|------------------|---------------|
| 1998 Control subjects: Special Ed, CA no treatment | –2 | 6 |
| 1997 Supportive–expressive preschool homeless, 40 sessions | –2 | 3 |
| 1980 Individual supportive–expressive foster children ages 3–13, 15 sessions | –4 | 30 |
| 1980 Individual supportive–expressive foster children ages 3–13, 40 sessions | 2 | 15 |
| 1970–1985 NY comparison preschoolers | 4 | 9 |
| Pooled control and supportive–expressive subjects | –1 | 63 |

Total number of control and comparison treated children = 63.

Cornerstone method has so far been demonstrated as raising the IQ of child patients significantly. The 12-point rise shown in Cornerstone therapy is three times greater than the rise among foster children within intellectually stimulating foster homes (Fanshel and Shinn, 1978; Freeman et al., 1928; Kliman et al., 1982). However, the Cornerstone method involves 6–15 hours a week of a classroom or group program for months at a time, and the PLHB method can be accomplished within 30 sessions, compressed into a couple of months.

Both methods have a feature especially relevant to traumatized children living in foster care. (We believe that “traumatized” is an adjective that applies to most such children before they ever arrive in a foster home.) The feature is that of providing a benevolent compensatory non-traumatic perspective. The method moves away from demanding therapeutic focus primarily or nearly exclusively on trauma. There is an antidote given to emphasizing repeated recall of the traumatic memories which plague the children. An entire social system is called into service, which includes a family network and often teachers and peers. Thus, instead of reinforcing and perhaps ingraining the neuropsychological and brain pathways, there is an opening up of new representations and a wide repertoire of adaptive tasks. This allows the child a respite from the potentiating effects of traumatic intrusions. In fact, like a good psychoanalysis, these analytic methods emphasize the development of as broad a repertoire of healthy coping as possible, moving from templates to creativity. The techniques provide additional focus on appropriate benign perspectives, develop corrective object relationships, and employ nurturant network creation components. They help children to mentalize, semanticize, think about, use, appreciate, articulate, and seek out what is good in life, rather than behaviorally enact traumas. The treatments go beyond therapeutically dwelling primarily upon the malignant past. This feature may help to make both methods clinically effective for etiologic reasons related to compensation for some of trauma’s neurophysiologic and psychologic effects. Those effects include production of chronic, harmful, reverberating, intrusive, constricting, and involuntary preoccupation with negative memories (Kliman, 1992, 1994, 1996, 1997). Both therapies are broadening, freeing, consoling, and vividly enliven a benevolent and mentalized here-and-now. Both methods encourage a coherent narrative exploration and expression of the child’s broad personal self and history. Neither elaborates only on the traumatic historical basis for a traumatized or disordered child’s self-concept.

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Gilbert Kliman MD
Medical Director, The Children's Psychological Health Center, Inc.
Distinguished Life Fellow, American Psychiatric Association,
Faculty, San Francisco Psychoanalytic Institute, USA
(gil.kliman@cphc-sf.org)