Journal of Child and Adolescent Mental Health 2004, 16(1): 39–43
Printed in South Africa — All rights reserved

JOURNAL OF CHILD AND
ADOLESCENT MENTAL HEALTH
ISSN 1682–6108

Clinical Perspectives

The Mifne Method — ISRAEL
Early intervention in the treatment of autism/PDD: A therapeutic programme for the nuclear family and their child

Hanna Alonim

The Mifne Center, PO Box 112, Rosh Pinna 12000, Israel
e-mail: info@mifne-autism.com, www.mifne-autism.com

The paper will present the Mifne (turning point) Method for early intervention in the treatment of the Autism spectrum, which has been developed as an intensive, short-term therapy programme for infants: the youngest infant treated at the Center was five months old. The Mifne approach is derived from attachment theory. The programme is designed to treat families with children under the age of five. The sequential programme includes three stages:

1. **Intensive system therapy for the nuclear family that continues for a three week period in residence at the Center.**
2. **Follow-up treatment takes place at the family home.**
3. **Integration of the child into mainstream education.**

A retrospective evaluation of the programme undertaken by the Schneider Children's Medical Center revealed that children showed improvement on almost all items of two scales: the Childhood Autism Rating Scale (CARS) and the Social Behavior Rating Scale (SBRS). Total scores on both scales showed significant improvement after three weeks and after six months. Follow-up data shows that 73% of the children treated at the Center have been integrated in mainstream schools. Clearly, early detection and treatment in the first year of life can redirect the infant's development and might avoid the escalation of autistic symptoms. An illustrative case study is described.

Introduction

The Mifne (turning point) Center was established in 1987. It was the first model of early intervention for autistic children in Israel that recognised the importance of individual therapy, intensive treatment and parental participation. The Center is located in Rosh Pinna, a village in the Upper Galilee, in Israel. The Mifne Center treats children under the age of five who have been diagnosed on the Autism Spectrum.

The Mifne approach is derived from the attachment theory that focuses on the importance of human bonding (Bowlby 1969). The basic concept underlying the therapeutic model practiced at Mifne views the family as an organic unit. The therapeutic environment based on principles of a bio-psycho-social model (Minuchin 1978), attempts to encourage gradual evolution of the child and each family member towards individual and mutual growth. A basic condition for this process is the ability to accept the child as having a potential that awaits realisation (Tustin 1992).

The Mifne method claims that understanding the child and his or her family's special needs, helps to lead them toward optimal realisation of the child's potential. The guiding principle of Mifne's therapeutic approach is based on work with the family unit in two parallel simultaneous tracks: with the child and family. Each family receives individual treatment.

There are three criteria for admission:

1. The child has been diagnosed as being on the autism/PDD spectrum.
2. The child is younger than five.
3. The parents are motivated and willing to take on therapeutic responsibility.

The nuclear family actively participates in the intensive therapy that begins with a three week period at the treatment center, working seven days a week for a minimum of eight hours a day. An aftercare programme upon the family's return home follows this.

During the residential period at the center the child is in one-on-one therapy. The number of hours is determined by the child's level of functioning. There are outdoor activities as well, mostly in the swimming pool and playground. The team of therapists observes the child through a one-way mirror and they record his behaviour using an evaluation scale that was developed at Mifne.

The therapists alternate every 90 minutes. Their objective is to encourage the child to respond and to seek ways to praise his involvement by using Reciprocal Play Therapy (RPT), developed at the Center. The work in the playroom is not guided by criteria of success and failure, and does not involve a system of reward and punishment. In the first stages of the therapy, the child is given maximum control over what happens in the room in order to help him build his self-confidence (Mitrani 1996).

Gradually a bond of trust develops between the child and the therapists. Their reciprocal exchanges slowly enable the

therapist to initiate activities to which the child reciprocates with social adaptive responses. Sensory stimulation and body contact are very dominant in the therapy. As the child's responses increase, new therapeutic challenges are available.

The questionnaire for evaluating the child's progress is completed by each therapist after each session. This form (Figure 1) includes evaluation scales such as eye contact, sounds, physical contact, concentration, curiosity and eating habits.

The majority of the children suffer from eating disorders, which are also treated in the therapy sessions.

Time/ Therapist	Acceptance of People		Eye Contact	Expression Wishes By Means of:			Initiative	Speech Sounds
				Pointing	Hand Pulling	Sounds		
From:	New [ ]	^ V	0	0	0	Screams<> Syllabels	0	0
			1	1	1		1	1
Until:	Familiar [ ]		2	2	2		2	2
		0 10	3	3	3	0 10	3	3
		1 9	4	4	4	1 9	4	4
	Enters	2 8	5	5	5	2 8	5	5
	With [ ]	3 7	6	6	6	3 7	6	6
		4 6	7	7	7	4 6	7	7
Name:	Without	5	8	8	8	5	8	8
	food [ ]		9	9	9		9	9
			10	10	10		10	10

Language Comprehension	Games and Cognitive Thinking				Physical Contact	Eating Habits	
	Curiosity	Concentration	Creative/ Constructive			Like a-	Amount
0	0	0	0	0	0	0 Baby	0
1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9
10	10	10	10	10	10	10 Adult	10

Daily Functioning		Repetative Paterning			Detachment	Comments
Personal Hygiene	Dress	State	Expression	Frequency		
0	0	Frustration		0	0	
1	1			1	1	
2	2			2	2	
3	3	Excitement		3	3	
4	4			4	4	
5	5			5	5	
6	6	Boredom		6	6	
7	7			7	7	
8	8			8	8	
9	9	_____		9	9	
10	10			10	10	

Figure 1: Evaluation form used by therapists

The family programme is designed to help the parents understand the basic principles of the method, which serves to improve their awareness of their life as a special family with special needs. This clarity contributes to the development of their ability to communicate with their child (Spensley 1995).

The Mifne method uses a variety techniques such as clinical meetings, verbal and non-verbal communication, individual and joint-couple meetings, family sessions, feedback on the parents' observation and team consultation with the parents. Special attention is given to the siblings in the family, who are included in the programme according to their age. The team of professionals includes a physician, psychologists, family therapists, special education teachers, infant and early childhood specialists and a nutritionist, all of whom have who have also been trained in the Mifne Method.

This short-term therapy aims to give the family the opportunity to reflect upon themselves and their special child, to reach a better understanding of their needs and to be able to consider each step of their child's treatment. In the process the parents learn that they can create a supportive, encouraging environment to help their child thrive. Parents are helped to continue the therapy programme at home; a member of the team supervises follow-up.

Gradually, opportunities for joining a social setting emerge for the child, the aim being interaction with other children. In most cases, at this stage a suitable kindergarten is chosen in order to allow the child's integration with his peers. This is a long process, sometimes taking a number of years.

In 2001, a team from the University of Tel-Aviv and the Schneider Children's Medical Center of Israel conducted an initial evaluation of the Mifne method (Apter *et al.* 2001). Their aim was to evaluate the status of a group of young children with PPD before and after receiving a period of intensive therapy at the Mifne Institute in Rosh Pina, Israel. Twenty-three children admitted to the Institute between 1997 and 1999 were assessed retrospectively. Trained professionals using the Childhood Autism Rating Scale (CARS) and the Social Behavior Rating Scale (SBRS) rated videos taken before and after three weeks of treatment at the Institute and after six months of continued treatment at patients' homes, blindly. Despite the small number of patients and the retrospective design of the study, the children showed improvement on almost all items of both scales including statistically significant improvement on several items in both scales. Total scores of both scales showed significant improvement after three weeks and after six months.

Furthermore, our own follow-up evaluation revealed that 73% of the children who have been treated at Mifne are attending mainstream schools (Figure 2). In terms of their development, ability to learn and communicate, the majority function quite highly (Alonim *et al.* 2002).

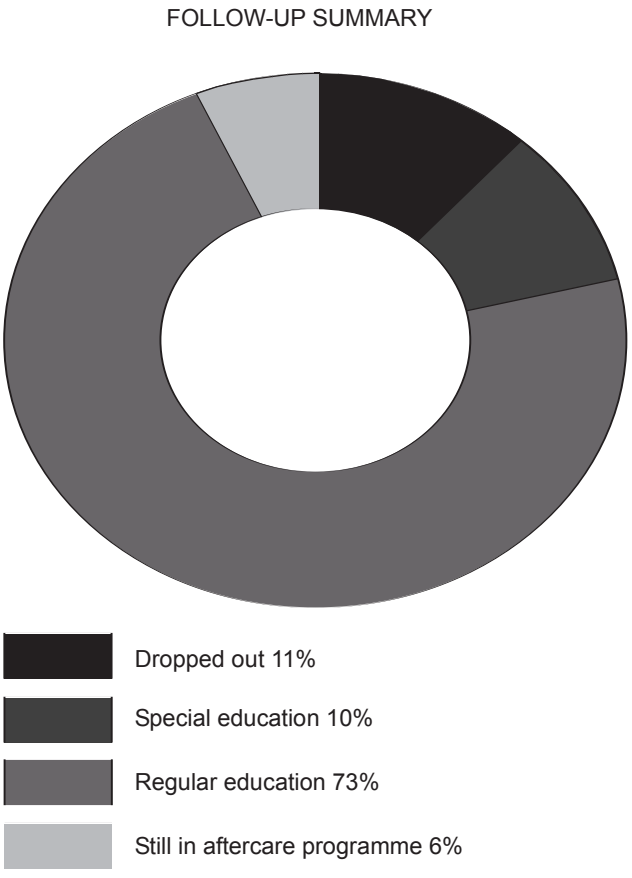

Figure 2: A summary of follow-up of children who have been treated at Mifne