

Web-Based Radio Show

Answers to Recent Questions About Creating a Program for Children with Special Needs


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May 19, 2005

Good morning. Welcome to our web-based radio show. This is Stanley Greenspan and today we have a number of topics based on questions that you all have been asking over the last month or so, and I've picked out the ones that occur the most frequently and the ones that I think are the most critical for understanding how to put together a program for children with special needs, based on our DIR/Floortime® Model. Let me jump in with these critical or very interesting and important questions.

The first one has to do with the challenge to families. We've talked about this before, but it's a continuing challenge for many families and, obviously, we need to go into greater depth on how families experience their relationships with each other and their relationship with their child with special needs, and how siblings experience their sibling who may have different kinds of needs than they have. These are clearly issues that are different for each family, but two overall patterns that we observe are that some families are able to organize around the challenge – as difficult as it is – and it brings the whole family closer together. Husbands and wives tell me that they're closer, sharing more information – more feelings – with one another, are more supportive to one another, and the family achieves almost a new level of what some families describe as “meaning” because they're coming together. The families that have this pattern often are able to experience some of the frustration and anger, some of the feelings of, “Why us? Why me? Why did my child have to have these challenges?” They're able to experience some sense of disappointment and loss in terms of the challenge that the child may not be speaking as early as they'd hoped, or the child may not be walking as quickly as they wanted him to, or the child may not be interacting as much as they had hoped, and this results in frustration, and fatigue and even anger, at times, but also loss and disappointment and sadness and even depression. Some families are able to experience that set of feelings, too, and as they go through these feelings and discuss them with each other – the two parents – they're able to come to almost a deeper set of values within the family.


What's remarkable for me to see from the sidelines, often, is the joy and pleasure that the family has as little Johnny or Susie begins smiling a little more or shows more of a gleam in her eye or is more interactive – what we call opening and closing circles of communication – or the child takes them somewhere for the first time to show them a toy that they want or some food that they want, or gives out that first precious word. What's



interesting, also, is what I find is parents often come to me with, “I want little Johnny or Susie to talk,” or “I want little Johnny or Susie to do well in school and to be able to learn to read.” What actually touches the heart of most parents is when little Johnny or Susie has that first gleam in their eye, when they light up and want to give Mom or Dad a hug and enjoy that hug, and have a big smile on their face. In other words, when the child begins engaging more, and showing more joy and love and intimacy in a comfortable way because we’ve helped the child enjoy relationships by figuring out how their sensory system works, or how their motor system works, so we can work around some of the processing challenges that are with them. That seems to be the first step in the parents’ really experiencing joy.

Then, as the child becomes more interactive and communicative there’s added joy and added meaning. When words come in, that may be a third level of joy and meaning, but the first is often something that many families don’t address in terms of their wish lists – it’s almost like it’s so important, it’s too important to even recognize or talk about. It’s not unlike a couple that doesn’t have quite the level of intimacy they wish for, they come in and their complaints aren’t “We want more intimacy,” but are, “He doesn’t do what I want him to do,” or “I’m getting all the hard work with the kids and he’s not helping enough.” Often there are power struggles around specific issues, not the fundamental issue of, “We’re just not close enough and not as open with each other as we used to be when we first met.”


Similarly, with children, often the most important part of the relationship – the intimacy, the gleam in the eye – often is beneath the radar, and yet once that starts happening it brings out the most fundamental kind of joy. So in some families there’s that ability to work through some of the difficulties and come together with a deeper level of meaning and almost a new level of satisfaction and depth of life where little things become important. It reminds me of adults who take everything for granted, but then have an illness and get scared about their own survival, and then all of the sudden every day becomes important, moments in the day become important, people slow down and literally smell the roses and realize the pleasures of taking a walk or looking at their gardens, or just having a good conversation with a child or with the spouse – little things that we’re taking for granted in the hustle-bustle of trying to get a job done or trying to get this or that thing accomplished. The slowing down, the appreciation of “little things,” comes because the adult has become scared about his or her own mortality, in some respects. What’s interesting is adults who have been through this experience will report that their life has more meaning now because they do appreciate the little things and they realize that the little things are actually the big things, and what they thought were the big things are actually the little things. So, the big business deal that they thought everything hinged on is not as important as the conversation with the son or the daughter, or the warm hug of a grandparent. For some families, the struggle of helping a child with special needs learn to be intimate, learn to be interactive, learn to communicate meaningfully what’s on their minds – not just scripts – has that same quality of making the seemingly little things the big things and changing the way the family works together.



So this is an ideal that all families I think families with children with special needs can strive for. At the same time, we have to realize that in many families there's a lot of strife and anguish and anger and frustration and sadness and depression and disappointment, and it affects the relationship between the mom and the dad, as well as the siblings, and there's a high rate of divorce, as a consequence. As high as it is in the general population, my sense is it's higher among families where a child has special challenges or special needs. What I see in families that are having a hard time finding that deeper meaning or working through these expectable feelings of frustration, anger, loss, disappointment and just exhaustion, is that the families get stuck in one or another of these feeling states – the feelings don't get worked through. The families aren't able to get to the point where they can find some deeper meaning and a deeper sense of relatedness among all family members. Obviously it's helpful in such circumstances to seek counseling or help at the earliest possible time so that the family can move ahead – not just so the family has more closeness and more harmony and more meaning, but the child with special needs will do significantly better in that atmosphere because Mom and Dad can't do better than their own mood. The program we're advocating here – helping the child learn to relate with warmth and intimacy and learning to communicate interactively, and then with words meaningfully – requires very available parents who are emotionally “there,” and if your emotions are drained with marital strife, or with anger and disappointment and depression, or with exhaustion just because of the work load because there's not enough sharing of the load, it's very hard to provide the child with what they want.

So, clearly, there's an initial shock when one recognizes there's a developmental challenge, and, clearly, there are strong natural human feelings of worry and concern, “Will Johnny or Susie be okay? Will they always have problems?” And, clearly, for most families there are anger and frustration, and I've never seen a family where there isn't disappointment or sadness, at least for a time. There's also just physical exhaustion – there's so much to do between doctors' appointments and therapy appointments and the home program that's intensive, advocating for your child in the school system, and just dealing with some of the behaviors that accompany the special needs condition – finicky eating, poor sleeping patterns, behavior control problems, including aggression or self-injurious behavior. Any one of these alone is enough to overwhelm, overload, and exhaust any one of us, and when many of them are present it is truly overwhelming.

So one should never minimize the amount of just pure physical and emotional stress that occurs. Siblings also are going to be pulled in to the challenges. The expectable reaction in a sibling that everyone talks about is jealousy because, “Little Johnny or Susie is getting all the attention and I'm not – I'm getting lost in the shuffle” is only one reaction that we see in siblings, younger or older, of the child with special needs once the other sibling who doesn't have special needs is old enough to think and old enough to verbalize his or her thoughts. But there are other reactions, too. There's anxiety whenever we see somebody having a problem. They always worry, particularly a young child, “Could this happen to me?” and that often doesn't get addressed. We're




focused on the rivalry and the “I’m not getting enough attention,” we don’t get at the deeper feeling, or even see it, that the child may be worried, “Gee, am I vulnerable? Could this happen to me?” But a child who can already think about “I’m not getting enough attention” can think about, “Gee, what if I lose my ability to speak?” or “What if I can’t show Mommy and Daddy what I want?”

Also, some siblings become very protective of their little brothers and sisters, particularly if it’s an older sibling, and therefore inhibit the normal, expectable rivalry that would be age-appropriate for a five- or six-year old and, instead, become protective or become a little mommy or daddy very quickly – sometimes too quickly. That can lead them to not be able to express their ordinary and assertive and competitive feelings in life. Other children take the opposite tack – they become very impulsive and aggressive with their younger siblings, almost as though they’re saying, “I refuse to be protective; I’m going to get what I want when I want it, no matter what,” almost disregarding the vulnerability of their younger sibling as though it doesn’t exist. That, too, can be a worrisome pattern because there’s a piece of reality that’s not being looked at. It’s almost like the older child, in this case, is saying, “It’s too scary to recognize, so I’m going to pretend it’s not there and I’m just going to go out and try to get what I need.” So it leads the child to be a little more self-centered or a little narrower in their view of not just their own sibling, but often in their attitude towards the world it can lead to a more self-centered attitude.

So this, too, can be a big challenge to look at. Obviously, there’s the siblings’ feeling of embarrassment in bringing friends over. If they haven’t embraced their younger sibling or accepted their younger sibling who may have special needs they may feel that somehow their friends will make fun of them because they have a sibling who has a problem. This is not something we would consider an admirable feeling to have, any more than a parent would feel admirable for worrying what other people in the supermarket or at the neighborhood school yard will think if their child is doing something unusual. And, yet, parents get very embarrassed very quickly if the child is spinning or self-stimming or perseverating in the supermarket and people are looking like, “What’s wrong?” If the parent experiences that, you can assume that the sibling experiences it about at about a hundred-fold intensity. Again, while not being an admirable feeling, it’s a very understandable feeling to have.

So, we have to recognize all these feelings that exist in families and in siblings: the sadness, the anger, the frustration, the disappointment, the depression, the marital stress, the blaming – each martial partner blaming the other one – siblings getting embarrassed or overprotective or under protective, and angry or impulsive. All of these are reactions to be expected and the more we can expect these reactions, recognizing that each family will be different, each family will have its own unique pattern and that it may include some of these elements – the more the family can become aware of that – then the more the family can get help if it needs help. But the first line is to have the mommy and daddy spend some time talking with each other about all these feelings. The more we




can be aware of them, the more likely we can get to that deeper level of meaning and that deeper level of understanding that brings the family closer together and solidifies the family unit. And even if the sibling is giving up some time to baby-sit and help out and do Floortime with his younger sibling in the summer, that can be a source of increased empathy and increased compassion and be an asset to that child for the future. So everyone can gain and the family can have a deeper sense of the meaning of life if there's awareness of and the ability to cope with some of these issues that I've just briefly outlined.

Now, next we're going to talk about some other issues. Okay, we're going to talk now about another question that comes up frequently, as I indicated, about the role of different professionals. Most children with special needs have a professional team that's involved with them, either at school or with private therapies, and yet parents are often confused and even policy makers are often unsure about the role of each of the professionals and how vital they are to the child's progress. If we have limited resources and have to prioritize because insurance won't cover some of the costs or the school system will only provide one or two of the professional therapies, which are the most important ones for little Johnny or little Susie?

Well, in order to answer these important questions and to understand the role of each of the professional members of the team, let's look back at our basic DIR/Floortime® and realize what it takes to put together a comprehensive program. Now, remember, when we look at the "D" part of our DIR model we're looking at what we call the child's functional emotional developmental capacities, and basically here we're talking about how the child's mental "team" operates as a team and at what level. Is the child struggling with attention and regulation, or engagement or being purposeful, or getting involved in what we call shared social problem solving, where they can have many circles of communication in a row – like taking Mommy and Daddy by the hand and walking them to the door and showing them where they want to go – or are they working more on using their ideas and words or are they working more on combining ideas together logically and getting to higher levels of reflective thinking? So where are they in terms of these critical developmental stages that we've outlined?

That's one factor we have to consider. And the second factor is other individual processing capacities – how well do they take in sounds and words? What do they do with sights? Do they understand what they see? How are they in terms of responding to sensations, like touch and sound? How well do they plan their interactions, in terms of what we call motor planning? That's the "I" part of our DIR – the individual processing differences. Then the "R," as you know, is the learning relationships – how well is the family tailoring those relationships to the child's individual ways of taking in sights and sounds, and to the child's developmental level to move the child to higher levels? Are there interferences in those family relationships that make it hard to do this, like family problems or family challenges? So once we look at our "D," "I" and "R" for each child, we have a profile of what that child needs, and based on that we can recommend




who should be part of the professional team and what each professional team member will do.

So, let's go back over this now and add in the professional team members. If a child is working on different levels of basic functional and developmental capacities, let's say she's working on basic engagement or being more purposeful and getting into a continuous flow of back-and-forth interactions, working on using ideas creatively for the first time, we're going to need somebody who helps Mommy and Daddy do the basic Floortime activities at home because it's what a child does every day that counts, not what they do once or twice a week, but it's what they do for hours a day. So, we want to be moving the child up the developmental ladder in terms of mastering these functional capacities, all the way from attention and engagement up to using ideas creatively and logically, hours a day during the six to eight Floortime sessions.

So who's going to be the Floortime coach? Who's the professional who helps the parents do that? Here, this can be many different people. One, it can be the parents themselves who do it. Let's say they're in an area where there are no trained DIR/Floortime® clinicians who can help them, and they may read a book like *The Child with Special Needs* or our Clinical Practice Guidelines, or now we have new parent versions of our training videotapes that are available at our Floortime Foundation website, www.Floortime.org or www.icdl.com, and now we've set it up so parents can have available to them a few of the case illustrations that are closer to the challenge that their child has, rather than have the whole set, but the whole set is still available, as well.

So, the Floortime video tapes, *The Child with Special Needs* book, the Clinical Practice Guidelines, and other articles we've written, along with a lot of other information available on the website, can give parents guidelines about how to create these kinds of interactions at home in their daily Floortime. But if there is a clinician who's trained in the Floortime approach, that person can serve two purposes – they can coach the parents on the Floortime and may also be the person who can help orchestrate the entire program. The ideal person here is a person with a strong background in working with children and families with severe developmental problems. It might be a clinical psychologist, it might be a child psychiatrist, it might be a developmental pediatrician – but it also could be an educator or a speech pathologist who has had special training or an occupational therapist trained in the DIR/Floortime® approach – who can help families learn how to tailor their interactions to their child and create playful interactions that will mobilize the child's progress up the developmental ladder.


So, this first professional is the team leader and the Floortime coach. Now sometimes the Floortime coach might be an educator – a teacher at school who has a lot of experience working with children – and a clinician who helps put the whole program together might be a developmental pediatrician or a child psychiatrist, maybe with a little less experience with Floortime, *per se*, but experienced with getting the whole team cooking and monitoring overall progress. So this role could be in one professional or could be separated between two professionals.



Then, when we come to the “I” part – the individual differences. In the evaluation, which may involve one person – again, it could be a child psychiatrist, a developmental pediatrician, or even an educator or a speech pathologist who’s trained to do a whole evaluation, or it may involve a whole team of people: a speech pathologist, an occupational or physical therapist, a mental health professional, a neurodevelopmental pediatrician, etc., as part of a team approach – but once the evaluation is completed, there’s a sense of what the strengths and vulnerabilities are in terms of a number of areas, including language and auditory processing. If there are challenges in this area, then we want a speech pathologist involved in the team because a speech pathologist will help the child make progress in strengthening auditory processing and language capacities. As part of the DIR/Floortime® program, the difference between what might go on or has gone on historically in speech therapy and what we would recommend to go on in a DIR/Floortime® based approach to speech, is that as the speech therapist is working on different areas and to strengthen those areas for the child – for example, she might be working with oral motor skills, exercises to strengthen and to make better use of muscles in the mouth so that sounds and words can be articulated more easily, or they may be working on receptive understanding, or what other people are saying, or expressing what’s on one’s own mind, or all the above, as is often the case – but, as one’s working on that, in the DIR/Floortime® approach, the speech pathologist is also working on those abilities in speech and language in the context of the overall progression of the functional emotional developmental capacities.

So, for example, while working on new words, we’re always working on those words as part of a continuous flow of back-and-forth interaction with lots of engagement. We’re working on the words coming in and being learned meaningfully, not in a scripted way. So, while the word might be prompted, we’re trying to set up challenges or problems to be solved so the child’s emotionally invested in using that word, right from the get-go. So, if we want to teach, “open,” we put the child’s favorite toy outside the door so the word “open” is taught as you’re opening the door to find your toy. So there’s meaning; in other words, there’s emotional investment in the word, giving it meaning right away, and that way it generalizes immediately. So, in the DIR/Floortime® approach to speech and language work, we’re combining the developmental stages that we’ve talked about before – the functional emotional developmental stages – in other words, having a child be attentive, engaged, involved in back-and-forth two-way interactions, getting involved in a continuous flow of interactions and using emerging ideas and words meaningfully and, eventually, logically – we’re doing that simultaneously with any specific speech or language goal we’re pursuing.

We have a new diagnostic system that we call the ICDL - standing for our Interdisciplinary Counsel of Developmental Learning Disorders - Diagnostic Manual for Infancy and Early Childhood and the initials are the ICDL DMIC, and it’s available at www.icdl.com, and in there we have a developmental approach to speech and language problems where we show how the problems or challenges can be thought of in terms of what developmental stage they stem from, and what part of speech and language is




involved from the oral-motor capacities, to the receptive or expressive capacities, etc. So, our speech and language therapist works on the auditory processing and language part of the “I” – of individual differences – but works with that in the context of our overall DIR model.

Now, if the child also – when we look at the individual differences – has challenges in motor planning and sequencing, or motor coordination, or low muscle tone, or has problems with sensory modulation – they are either over reactive or under reactive to basic sensations like touch and sound, or they have difficulty with what we call sensory discrimination – the ability to understand and comprehend information taken in through the senses, so they get too close to people or intrude too easily into people or don’t understand what they’re holding and they can’t identify objects by feel and touch – they could have what we call “motor planning” or “motor coordination” problems or sensory modulation problems or sensory discrimination problems or problems with postural control and basic coordination. If any of these are the problems or challenges as part of the “I,” then we want an occupational therapist or physical therapist working with the child. And the training of the occupational therapist or physical therapist will determine which one needs to be the one involved. Typically, if the problem is more with severe low muscle tone and coordination, including conditions like cerebral palsy, it will be a physical therapist that’d be involved. If the problems are more involved in sensory modulation and the child is over or under reactive to sensation, or motor planning and sequencing, i.e., if the child is dyspraxic, it will more likely be an occupational therapist involved and one who’s trained in sensory processing and motor planning and sequencing. Sometimes occupational therapists who are trained in these areas use the term “sensory integration training,” because sensory integration focuses on these areas.

Often, both the physical therapist and occupational therapist could be involved. Some physical therapists are trained, however, in occupational therapy strategies and some occupational therapists are trained in the physical therapy strategies and, therefore, you may only need one person, even with a child who may have low muscle tone and severe coordination problems, as well as sensory processing challenges and motor planning challenges. So, here, you need to see the training background of the occupational therapist and physical therapist. But if there is a problem in the area of motor functioning and sensory processing, then we’ll need a physical and/or occupational therapist involved in the team. But, here, too, it’s what you do every day that counts. We want the professional – just like the Floortime consultant and the speech consultant to influence the daily program of the child, and I’ll get to how we do that in just a moment, but we want the parents to be able to carry out the program every day at home, as well as what goes on in the professional therapies.

While it’s ideal to have such an individual available to your child as many times a week as would be optimal – and sometimes that means three or four times a week or even daily speech therapy and/or occupational therapy or physical therapy – in some settings this is not possible and, therefore, the specialist – the professional therapist – needs to be




a consultant to the team. The team may involve educators or the team may involve parents and volunteers and they will actually carry out the day-to-day activities under the guidance of periodic visits to the specialist. The important point is that the child has the experiences he needs and not to have the child not have these experiences because the therapist is not available as frequently as would be reasonable or even adequate. Often I find this is not done – if the school system is strapped for funds and they can only give once a week a half-hour of occupational therapy, that may be all the child gets, rather than that person instructing the teachers on how to work with the child, and the key is to change the teachers' effort and work with the parents so the parents can do it at home. Often it'll happen with a few of the teachers, but rarely is it communicated effectively to the parents. In those cases where it is, I applaud those schools and those therapists who are doing that, but we need more and more of that. So, there are many excellent therapists who do work closely with parents and educators, and many parents and educators who do implement these suggestions on a daily basis as part of the home program, which we'll go through in just a second, but we need to do more of that.

There are other areas, too, in addition to speech therapy and physical and occupational therapy. Some children have difficulties in what we call visual-spatial processing where it's hard for them to comprehend what they see. They may be able to see and recognize there's a door or a table, but they may have trouble tracking things, so a moving object is hard for them to follow. Later on it will be hard for them to track words across a page and read.

Other children may have difficulty with their bodies in space, and knowing the difference between the left and the right side of their bodies and or getting out of the way of a moving object. They may have difficulty figuring out how to move their body in relationship to other bodies or physical objects or other people in space. They may have difficulty with figuring out size and shapes based on what they see and, therefore, have difficulty with quantity concepts and understanding basic concepts of math and science as they become more verbal. They may have difficulty understanding how objects can change based on perspective – when you look from the side or from the back. So, these are all challenges we may see in the visual-spatial arena, which is just as important a source of information as what we hear – what we take in through sounds and words. Some may argue even more so. When children have severe difficulties in visual-spatial processing, we often have a lot of “nonverbal learning disabilities” because it involves the nonverbal areas of the mind or the brain.

So, on the original evaluation where it's noticed a child has trouble searching for hidden objects systematically, or is confused about their body in space or left and right or, as I mentioned, and can't search for hidden objects, we need to also begin a program that helps their visual-spatial side. Here, an expert who deals with visual-spatial processing is an important member of the team to work directly with the child or to help the teachers or educators and the parents include this component into their daily work with the child. There's a wonderful book by Harry Wachs, one of the pioneers in visual-spatial



processing, called *Thinking Goes to School*, that outlines some of these areas I'm talking about in more detail. In our new diagnostic classification system, the ICDL DMIC, we have an axis on visual-spatial processing. So we recommend that every child, as part of their diagnostic evaluation, also be observed in terms of where they are in visual-spatial processing. So we may need an expert in this area, as well.

Now, another member of the professional team are the educators and special educators. As children are progressing up the developmental ladder and learning their basics, learning how to attend and relate, and interact purposefully, and problem solve in a continuing way and use ideas creatively and logically, they can begin the more formal elements of their educational program, and here the educators and the special educators become a critical part of the team. For some children, they become a part of the team much earlier, even as they're working towards these higher levels. The educators generally will focus on "cognitive" skills and academic skills, but really the role of the special educator needs to be more broader, and we have advocated in our DIR/Floortime® model that the IEP goals for educators first and foremost focus on our functional emotional developmental capacities – that these are our first educational goals: the ability to attend and engage, to be purposeful, which is the basis for being logical and reality-based, to be problem-solvers through gestures and then to use ideas creatively and logically – because without these six levels in place a child doesn't know how to think. The thinking occurs first through using gestures purposefully, as part of being involved in a related relationship, and then it occurs at the level of ideas, by being able to connect ideas together logically. But to do that you've got to use ideas meaningfully first – you can't just be scripting ideas and get logical thinking. Now there isn't any educational enterprise past the third grade that doesn't involve logical thinking and problem solving. So, one time a parent said to me, "Well, we're working on the functional emotional milestones, but we're not working on his academics. We decided the functional emotional milestones are more important." I said, "Wait! No, that's not the trade-off." I said, "These functional emotional milestones – the ability to relate and think creatively and logically – are the same as the academic abilities. They are the first academic skills because without them there are no other academic skills!"


So the notion that you can memorize some letters or shapes or numbers, and you can memorize a few words or even learn to read does not constitute academic skills and is just flat-out silly. The fact is that if you want to understand what you read, you have to have a meaningful grasp of words and language, which means being able to use words, obviously, logically and meaningfully, i.e., it means the ability to think. So, really, the first academic skill is thinking, so that's why we advocate that the IEP involve the functional emotional capacities, and these goals can be made very concrete and objective. We want to help the child go from engaging a little bit at a time, to half the time, to most of the time. We want to help a child be purposeful from a little bit of the time to most of the time. We want to help a child open and close 50+ circles of communication – again, from a little of the time to almost all the time.



We have a seven-point rating scale so you can make these IEP objectives very, very clear. We want to help a child use ideas creatively and logically, again, a little of the time to most of the time. Once we've achieved that, we can focus on being able to use numbers and letters meaningfully and logically, again, from a little bit to most of the time. Then we can work on reading and higher-level math skills. Then as we go on to different content areas, like history or science, we can also focus on goals within our DIR/Floortime® model by making the curriculum a thinking-based curriculum. In other words, we've outlined – as many of you know from prior sessions – different levels of thinking, from using ideas logically and meaningfully to using ideas in a cause and effect way, then in a multi-causal way, to do what we call comparative thinking, where a child can compare two things A versus B – the Civil War and the Revolutionary War – and then where a child can do what we call gray area thinking, look at shades of gray of things – of all the reasons for the Civil War, which were the most important and which were the second most important; and, then, eventually, thinking off what we call an internal standard, where a child can evaluate his own thoughts, “Gee, that was a good essay I wrote or a not-so-good essay,” or, “I agree more with Tolstoy and less with Mark Twain for the following reasons.”

So, to get to high-level academic skills requires high levels of thinking. We can relate all the academic content we want to teach – history, science, social studies, English – to different thinking levels so that each lesson becomes not just a lesson in that particular content, but it becomes a lesson in thinking. So, when we're learning about the Civil War we don't just memorize dates and generals and battles, we talk about it from the point of view of the reasons for the Civil War and we do that at different levels, from the basic reasons to eventually gray area thinking, where we're choosing which one is more important and which one is less important. We talk about how we would have experienced it if we were in the South or we were in the North, getting to very reflective levels of thinking. We try to understand the perspective of the different people involved, those who were slaves, those who were landowners and those who were fighting to free the slaves. So you can imagine how a thinking-based approach to content would differ dramatically from just a memory-based approach. For children with special needs, it's critical that everything be done in a thinking-based way.

So, this is a long-winded commentary on our educators, but our educators and special educators using our Floortime model have to work on the basics of each of our functional emotional developmental milestones, and have that serve as the cornerstone of their IEP, and then we involve a thinking-based approach to academic life. And there's one other piece to our educational program in our DIR/Floortime® model and our educators as members of the professional team, which is that also we want to use academic work to strengthen all the processing capacities. For example, a child who can't discriminate sounds well because of auditory processing is not going to be able sound out new words very easily. So we need to work on auditory processing as we're working on reading, and so phonemic-based approaches to reading are going to help with auditory processing. In this way, similarly, when they're writing essays, a child who has




poor fine motor control may find it very frustrating to write that essay, and we want to work on fine motor skills and also provide other ways of communicating information, either through talking through a tape recorder or typing so that the child isn't limited to penmanship, which may slow down his or her thinking processes and may undermine his or her ability to master the form of an essay. So we want to do both: strengthen their fine motor skills – strengthen the penmanship – but also provide alternative ways to communicate so the child's ability to think and construct the essay occurs anyhow. In our DIR model, the educational approach includes strengthening each of the processing capacities as we're learning and as we're in the academic program. That's what our educator does.

Also, as indicated as among our professionals, we have many families with family challenges, where there are conflicts between husbands and wives who blame each other, or are angry at each other, or who haven't been able to work through their frustration and disappointment and anger to some deeper meaning with each other, and need some help. So they need a family counselor or a mental health professional involved as part of the team. That can be a very, very vital role for the team members.

For some children, there will be other specialists involved, involving art or music, horseback riding or different kind of physical exercises. So, other professional may be involved, as for any child. Again, when we do this in a DIR/Floortime® approach, everyone working with the child is working on the fundamentals of the “D,” “the I” and the “R” while they're pursuing specific goals of that particular processing area. So whether we're working on educational goals or speech and language goals or motor goals in physical therapy or occupational therapy, we're always working on the fundamentals of the six basic functional emotional levels and strengthening as many other processing abilities as we can, along with the one we're working on as our main focus. That's the heart of our DIR model – we're always getting the whole mental “team” working together and working to master higher and higher levels of the child's developmental capacities.


So this is a quick overview of what the different professionals do. Now, what's most important to emphasize, however, is a point I made earlier, which is that parents are going to vary in their access to the professionals based on where they live, what their personal finances are, what kind of insurance coverage they have, and what kind of school system they're involved in, because the access to speech pathologists or occupational and physical therapists or special educators is going to vary significantly based on all those factors. What's most critical for the child, however, is what happens in their daily program. Here's where I've seen gifted parents who read on their own, receive consultation periodically from different members of the therapy team we've talked about – depending on what their child requires – and then they carry out the lion's share of the program at home themselves, or with volunteers or with extended family members, or by hiring some high school students or college students to help and put together an excellent daily program for their child. Some parents elect to home school



because the school can't provide what the child needs, or they compromise and have the child do a half-day in school, more for socialization, and then a half-day at home working one-on-one with them or with volunteers or helpers, such as high school, college, or graduate students. And in some of these families the professionals of the team we've mentioned are only available once a month or once every few months, sometimes even only through telephone consultations because of where the family lives, and yet in spite of those limitations I've seen those families and those children thrive.

So, some of the best progress has been made in areas on the country where there's nobody within a 300-mile radius of the family who can provide these services. But that family has, through reading and through telephone consultations and through periodic consultations with the organizing clinician or with some of these specialists we're talking about, has put together the program for the child to work and have daily fun and enjoyment, and it's that daily program that counts. So, while it's ideal to have access to all the therapies – and for many children with autistic spectrum disorders the optimal program is three or four speech therapy sessions a week, three or four occupational therapy and/or physical therapy sessions a week, special educators involved with the child, the child being in an integrated program where there is access to very interactive peers, as well as other peers who may have similar special conditions, lots of opportunities for play dates in the afternoon, an active home program doing lots of Floortime six to eight sessions a day, plus also what we call problem-solving interactions where you work on the occupational therapy as well as speech pathologies, as well as some of the visual-spatial goals as well as dietary and nutritional consultation – many families are able to implement optimal programs without such access. (I haven't mentioned the nutritionist as part of the team, but that is another vital component of the team.) So we have all of these working together in an optimal program – through the school and through professional therapies and through the home program – but, again, I mentioned that this won't always be the case and we have to be prepared to enhance that child's daily experience.

Now, there are a couple of professionals I have not mentioned that I'm realizing as we're going through this. One is the biomedical expert, who is usually a physician from one or another specialty, either developmental pediatrics, child psychiatry, or pediatric neurology, and this is an important one because this person can be the overall team coordinator, monitoring the child's progress. He or she could also be the DIR/Floortime® consultant to make sure all the elements of the program are orchestrated. This person can also consider whether medications or dietary modifications are needed, and there's a big range of opinion among physicians about the proper biomedical management for children with autism. For example, there are a number of medications now that have been helpful for certain kinds of children, and we won't go into all these at this particular point except to say that you want to have a biomedical expert as part of your team, and that every child requires an evaluation at the beginning to rule out a biomedical basis for the disorder. Most children with special needs have a biomedical reason for their special needs condition, and autism clearly has a biological basis, and for




many disorders, including autism, the nature of the biological origins of the disorder is not well understood, but it's essential to rule out any known organic or physical reason for a child with developmental problems, including autism. So the biomedical expert has to be there at the beginning doing the proper blood tests and proper physical examinations, including, often, a 24-hour or extended sleep EEG to rule out a physical basis for the disorder. It's especially important to rule out a regressive developmental disorder related to a metabolic disturbance or a genetic challenge. Then the biomedical expert is important to be available to see if biomedical factors can play a role in the overall management of the child and that input is very important – the biomedical expert need not always be involved on a regular basis with the child, but periodic visits for updates and monitoring the child's progress and reconsideration of biomedical factors is highly advisable.

Also, as I mentioned before, nutritionists are often helpful. Many children have challenges with eating, some children have GI problems and, again, there's a range of opinion among nutritionists about different nutritional approaches that may be helpful, although much of the research hasn't yet been definitive in terms of the role of nutritional approaches, but that opinion and feed-in into the thinking of the child and the team is very important to consider.

The different professionals we're talking about and their role is further elaborated on in our Clinical Practice guidelines at our www.icdl.com for those who are particularly interested in these questions.

I want to say one more word about the professional and the professional team. This is a very, very important principle, one that often gets overlooked. It came up just the other day when I was having an opportunity to give a talk to the Academic Pediatric Society, the American Foundation of Pediatrics, which was meeting here in Washington. One of my colleagues on the panel was talking about a particular technique having to do with sensory processing not being proven in the literature, and I responded after his comment to the audience that we had to make a decision between a specific technique looked at in isolation versus as part of an overall comprehensive program. Often we make a critical mistake when we say that technique A or technique B has not been proven in its own right to be helpful. But the real question is that in life we don't use technique A or B in isolation, and to assume that something used in isolation is the same as something that's used as part of a complete program is something that is incorrect. It's making an arbitrary distinction. It's a little bit like saying if you take your arm and you disconnect it from your body, will it be able to pick up and throw a ball? Well, no, probably not, but if it's connected to the body your arm might be quite effective. Well, similarly, using a particular technique, connected to the body of the whole program, it may be quite effective. Yet, if you look at in isolation, cut off from the body, it may not show that effectiveness. And often we make that mistake. So, for example, if someone had severe heart disease and you looked at people with the most severe heart disease and they didn't lose weight and didn't take appropriate medications for their cholesterol and



you only had them, while overweight, do a rigorous exercise program they might get worse because the rigorous exercise program might stress their already vulnerable heart, and with their high cholesterol and their other challenges, it might actually make them worse. At the same time, however, an exercise program as part of a nutritional and diet program, as part of appropriate cholesterol-lowering medications and medications that might lower their inflammatory reactions in their body, like some of the statin medications are now doing, it might be quite effective. In fact, evidence suggests that it is, but we wouldn't study the nutrition or just diet alone, or if we did it might give us a false negative rather than a positive, again, because in real life the whole is more than the sum of its parts and the parts can't always be isolated from the whole. And yet, with specific therapies for children with special needs we've made this mistake.

So, some people have looked at particular motor-based exercises or sensory-processing exercises saying, "Do these things cure autism in its own right?" Well, of course it's silly to even suggest that they could! But do children with autism have motor planning and sequencing problems? Are they over reactive to sensation? Is that well documented? Well, that's been documented in hundreds of studies now. Therefore, should those problems be addressed in some way as part of a comprehensive program? Well, we'd be foolish not to, any more than we'd be foolish not to address the speech and language part of the program, but doing oral motor work alone, without anything else oral for a child with autism is unlikely to show very good results. Oral-motor work as part of a comprehensive program is likely to be very helpful to the child in learning to speak. So, we have to look at elements as part of complete programs and then measure the outcomes that are related to those elements and related to our complete program objectives. If we want to say, "Okay, it doesn't make any difference, this element," we can measure a program with or without it being present and see if that makes a difference. That's the relevant test, not looking at the element in isolation. That's a frequent mistake we make when we evaluate programs, so this is a very, very important point to underline and often gets ignored.

It's time for us to wrap up for today. Next time, which will be next week, we're going to continue with a few of the other questions that have come up today that I want to get at. One has to do with limit setting, and another has to do with helping children be more responsive to things we say when they're tuning us out, plus other questions that have arisen. So next week we'll catch up on a few more critical issues like we have had today. So, thank you for joining us. This is the end of our show today and we'll see you next week at the same time.