



Web-Based Radio Show


Finding the Best Program for Your Child

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July 22, 2004

Welcome to our Web-based Radio Show. This is Stanley Greenspan. Today we have a very interesting topic. We are going to be talking about how to figure out what the best program is for each and every child. We know that every child is different and every child requires a very special program to meet their special needs challenges.

When parents confront the issue of how to help the child with special needs, and especially children with pervasive developmental disorders or autistic spectrum disorders, it can be very, very confusing. Parents often read about or hear about or are recommended a vast variety of approaches. Many of them seem very different from one another. Some emphasize changing behaviors. Others emphasize building relationships. Others emphasize working on academic skills. Others emphasize just specific therapies like speech therapy and occupational therapy. How is a parent to know, or an educator or a medical or mental health professional who hasn't been specifically trained to work with children with autism or other special needs conditions, how is one to know what particular program or approach to recommend for a particular child? Sometimes communities or areas of the country tend to follow one or another approach. Does that mean that that approach that is followed in the Midwest or in a county in Oregon or a particular school system is the right approach for Johnny or Susie? Can one approach be the appropriate approach for all children when children differ so dramatically? And, what is the difference between an approach and a comprehensive program? For example, to use an analogy, if somebody has heart disease, a specific approach might involve taking a specific medication. But that medication is only one part of a comprehensive program. Or their doctors may recommend diet and weight loss or exercise, but that too, may be only be one part of a comprehensive program. A comprehensive program for heart disease, as we know, may involve nutrition and diet, medication, reducing anxiety levels, and many other particular interventions. So a program often is one component of a comprehensive approach. So the real question that parents and everyone else needs to answer is: How do we develop a comprehensive approach for a particular child, and how do we know which program elements or which particular techniques are going to be best for that child?



In the following comments, I'm going to try to address this question so that the parent and the educator or clinician who hasn't been specifically trained to work with children with autism and other special needs conditions, can make an informed judgment about this critical question. I can't emphasize how critical this question is because the program or the comprehensive approach selected for a child, in my experience, does make a big difference. Children with special needs and especially children with autistic spectrum disorders are not pre-set to make certain types of progress, or are not pre-set to be limited to certain levels of development. How we work with a child; what we do has enormous influence, and I emphasize the word "enormous" – *enormous* influence on how that child will progress. It doesn't mean that the ideal program will mean that every child will progress to the level we wish they could. Other factors, including neurological factors will obviously influence the way the child progresses. We can never tell what a child's full potential is unless we have a truly optimal program for that child; unless we help the child reach that, and that means an optimal and comprehensive program.

So how do we determine that? How do we figure that out for the individual child? The first question we have to ask is, how do we understand the particular child's needs? To pick the program, we have to know what we want to address, what are the challenges or problems the child is facing. That may seem like an easy question, well my child is lining up cars, or my child repeats words and is echolalic, or my child keeps staring at the fan, or my child keeps opening and closing the door, so what I need to do is correct that behavior. But, it's not so simple. Is that the only problem? Is that the only challenge the child has? Or does the child have a more fundamental challenge?

1. For example, how does that child enter into what we call a state of shared attention? Can that child look at you and listen to you and share information with you in a calm and regulated way? Well, if that is not present, that's even more fundamental than lining up cars or repeating everything you say.

2. How is that child engaging with you? Is there warmth and intimacy? Does the child seek you out with joy and delight and a gleam in his eye? Does he enjoy being close to you and with you and interacting with you? Well, if that's not present, that's also even more important than whether the child is lining up cars or staring at a fan.


3. Is the child able to be purposeful; able to nod their head yes or no or show you with a hand gesture what they want or simply exchange lots of smiles in a row or lots of different sounds, even if they are not talking? In other words, can they interact with you in a purposeful way? Can you get what we call two-way communication cooking? Again, if that's not present, that too is even more fundamental than some of the behaviors we talked about before.

4. How is the child at problem solving? How is he at opening and closing many circles of communication in a row and solving problems with your help, such as taking you by the hand, pointing to the toy up on the shelf, and then gesturing with their hand and with their sounds to get you to pick them up so that they can reach the toy? Can the child do that? Can the child, in other words, put together many little interactions into a big problem solving pattern to let you know what they want and get your help in getting it? If the child can't do that, that too is more fundamental than the specific behaviors we were talking about.

5. How is the child at putting their intentions, their desires, their wishes, or their feelings, or their goals into words? "Mommy, go outside" or "Mommy, want juice" or even better, "Mommy, I love you." How is a child at expressing their needs and wants and desires in words or symbols? If they can't use the word, can they use a picture? Or can they use a sign as in sign language? Can they make up their own sign? Can they use a symbol system? Again, if a child isn't able to do that is over age 2 ½, that too is more fundamental than the specific behaviors we may be concerned about.

6. Lastly, how is the child at combining their ideas together so that they can be logical? When they say, "Mommy go out" and you say, "Why?" can they say "Because I want to play" or "Because it's nice out there" or "Because I don't want to be inside." In other words, can they combine ideas together to be a logical thinker? Logical thinking then builds higher levels of reflective thinking where they can get to have real debates with you and discussions, and then be able to learn in school and do math and science and comprehend what they read, not just learn to read but learn to comprehend it. So can they learn to be thinkers?


So what I just outlined are six fundamentals. So the question we have to ask ourselves is, what are the behaviors we are concerned about? Like staring at a fan or lining up cars or repeating everything that someone else says without actually understanding it, or reading books and just memorizing them but not being able to talk logically or just rubbing a spot on the floor or even scary things like banging one's head or just running around aimlessly in circles. Sure, these are behaviors we are concerned about, and we want to notice those and list those. But then we also have to ask the second question: Where is the child on these six fundamentals that I just mentioned, from sharing attention to relating – always up to communicating and thinking? We have to identify which of these fundamentals the child has mastered, and which ones the child has not mastered. Or, we need to identify which one the child has mastered fully and which ones only partially; only a little bit. Because many children master some of these but just a little bit, for example they can relate and smile and enjoy closeness when you seek them out, but only for a few seconds, and rarely seek you out for it. So that means



they have a little bit of mastery relating, but not full mastery like we would expect for a three or four year old.

So we ask where the child is on these foundation pieces or these fundamentals; these six fundamentals that I've outlined, have they mastered it a teeny little bit, a medium amount, or all the way or fully for their age? That's not a technical question that only a professional could answer. Every single parent can answer that question, and in fact, parents will answer it much better than the clinician doing the assessment. Why? For a simple reason: Who knows the child better? Who is spending hours and hours a day with the child? The clinician may see the child for a couple of hours, but mommy and daddy are seeing the child for hours and hours every single day for years and years. So who knows better about the child's capacity for intimacy and relating or the child's capacity for taking you by the hand and walking you to the door and showing you that they want to go outside. That is something that mommy and daddy are going to know far better than anyone else. Schoolteachers even know that well too because they'll see the child everyday. So it's the people who know the child best that can answer these questions the best. The professionals can help you ask the questions. But you have to be the ones to answer them. The professionals can observe with you if you are not sure. But when there is a difference of opinion, you can get the professionals to observe with you more and more until you come to some consensus.

So the second question in addition to the problem behaviors is: Where is the child on the fundamentals. Now why is that important in picking a program? Well, there is an obvious answer to that, and one that I think all of you would conclude even before I even say it, which is, the comprehensive program has to help you help your child master these fundamentals. If we just help the child stop staring at the fan and we don't teach him to relate or communicate, we are helping the child just a teeny, teeny little bit. We aren't helping the child nearly as much as we could or we want to. So identifying the fundamentals, and which ones are missing and which ones are only partly mastered, tells us where we have to address the intervention. That's a big choice to make because if we just work on stopping the child from staring at the fan or stopping the child from lining up cars, and we don't work on sharing attention or on truly enjoying relationships or if we teach a child to look in someone's eyes but don't teach the child how to love the person who's eyes we want them to look into, we are going to be not helping that child as fully as he needs and as we want to. So we need to identify the fundamentals to know what sort of intervention is right for that child. For example, if the child's problems are just with some repetitive behaviors and it's a child who can attend and relate and communicate and use words to communicate wishes and to think organized and logically, but he just has a little bit of a tendency to be aggressive or to occasionally line up his cars




or to occasionally stare off at a fan, we may be able to focus just on the behavior because all the fundamentals are in place. That means we are working on a very small problem. However, if we are missing some of the fundamentals, then we've got to ask ourselves the question: Is the intervention approach that we are selecting going to help us with those fundamentals? We have to find an intervention approach that will. As part of a comprehensive program, we can address many different components at the same time – the behaviors and the fundamental building blocks for relating, thinking, and communicating.

Now there is another set of questions you need to ask yourself, however. Equally important to the fundamentals of relating, thinking, and communicating are what we call “the processing capacities” that help the child master the fundamentals. In other words, by processing capacities we mean the way the child takes in information and also acts on the world or gives out information. So in taking in information, the child hears and listens, hopefully takes in sounds, but also has to make sense of those sounds. He has to comprehend them and then understand what they mean. So you have to be able to hear, you have to be able to decode or see the pattern of sounds, and then you have to be able to figure out what those sounds mean in terms of the words. Like what does “apple” mean? What does a “hug” mean? What does “going outside” mean? This is a big job for the brain to do. But it's not just what we call “auditory processing and language” or “hearing and comprehending” that's important. The child also needs to also take that same capacity and use it on the outflow side – use it to communicate what they want. They have to be able to make sounds, not just understand sounds. Eventually they need to be able to form words and form words that have meanings that make sense to others, such as “I want a hug” or “I want to go outside.”

Now if the child has trouble with the outflow, not because of the thinking part but because of the motor part – they can't make the sounds with their tongue and mouth, often children can learn to type out what they want to say or they can learn to use various electronic supports where they press a button that has a symbol for what they want to say and the machine then talks for them. Or they can use pictures or various signs with their hands or a sign system like PECS. So there are many ways to augment the outflow system. But children need to master this basic processing capacity as a part of one of our foundations for communication.


But there are others too. For example, children are helped by understanding what they see. It's not just figuring out sounds, but when they see mommy or daddy, do they recognize them? Are they familiar? Do they put the eyes and the nose and the ears and the mouth and the arms and the legs together and form an image of a whole person? Now that may seem like just something that everyone does, but a newborn baby doesn't do



that. A newborn baby may just see the eyes or the nose and not yet have a gestalt or a sense of the whole. But pretty early in infancy, children are beginning to be able to discriminate or to figure out or comprehend the whole face and eventually the whole body. But even when your child, as a baby, can see the whole body and see the pattern, that doesn't mean that they know that is mommy or that is daddy, because that means what you see has meaning, and it has emotional meaning. In other words, that image of that woman with red hair and a blue dress and two arms and two legs who is there everyday smiling at you, at some point she becomes "mommy." That is because you give her meaning because of all the feelings and experiences that is associated with that visual image. So visual images like words acquire meaning over time. But to do that, the brain has to be able to put together all your experiences together with what you are seeing. So you have to be able to see, you have to be able to see patterns or the big picture, so to speak, and then associate that with your emotional experiences. So you have a visual image now; a meaning. So we call that "visual spatial processing" or "visual spatial thinking." That, too, is part of relating because obviously it is hard to be loving if you don't recognize someone as your mommy or your daddy. So that helps with relating, communicating, and thinking also.

There is another area in the processing area that helps called "motor planning and sequencing." That is basically, in very simple terms, the ability to carry out actions; to do things with your body – reaching for an object, pointing, exchanging food, tying your shoes, running, going through an obstacle course – all of that involves actions, i.e., your body or your motor system. What we know is that children with special needs, just like they vary or have differences in the way they use language and understand language and the way in which they understand what they see, also have differences in the way they take actions on the world. Some children can only do one or two step actions like banging a toy on the table or moving a car back-and-forth. Other children can do four or five step actions. They can take the car, roll it to mommy, then roll it to daddy, then put it in the little house, then roll it back to mommy again. That is a five-step action. Now the more actions you take in a row, the easier it is to problem solve and the easier it is to learn to think, and the easier it is to communicate because communication itself, involves many complex actions of your body, as does relating. So that, too, is very important for the fundamentals and the building blocks of relating, thinking, and communicating.


Problem solving involves lots of actions in a row in a meaningful way – it's a very, very vital part of thinking. So that too is important. Then we have one other component of our physical makeup that is critical, which is how we modulate or regulate sensation. We know that some children with special needs, especially autism, are over- or under-reactive to basic sensations such as touch and sound. So for some children, even



the normal human voice can be over-stimulating. For other children, it's under-stimulating – they hardly react to it. So children can be over- or under-reactive to things like touch or sound or movement in space. Some children love to be swung and other children get scared when you swing them around or when they climb up on something high.

So sensory modulation or the ability to regulate sensation is very important too, because if the human voice is irritable to you because it feels too shrill, it's harder to relate and communicate, and then it's harder to think. So these processing capacities, or in general lay terms – these abilities to take in information, make sense of the information, and then do something back out; communicate back to the world and take actions on the world – these fundamental abilities which are part of our nervous system, they support these foundations for relating, thinking, and communicating that we have just been talking about – these six milestones. So we have to know, also about our child, what are his or her strengths or weaknesses in taking in sounds and words and using words and sounds back, what are his strengths and weaknesses in understanding what they see in operating on the world through vision? What are his or her strengths or weaknesses in terms of planning actions? What are his strengths or weaknesses in terms of being able to regulate basic sensations such as touch and sound and movement, so they aren't overwhelmed all the time or under-whelmed to such a degree that they don't take an interest in the world? Obviously if we don't know the answers to these questions, we won't know what some of the underlying reasons are for the child having difficulty in relating, thinking, and communicating. So that, too, tells us the profile of the child.

Then, there is one last set of questions we have to ask to know the child, which is: What types of experiences, what types of interactions at home with mom and dad tend to work for that child to help the child share attention, relate, communicate with gestures, and if the child can communicate with words to use words, and what kind of experiences don't work for the child. For example, leaving the child alone may lead him to be aimless. Lots of sensory play may help him smile and giggle and want to be close to you. Some children do better when they are in a swing – they use more words. So what kind of experiences work for the child? Some children need to be wooed with high energy where you activate up and you are very energetic and use very energized words and a lot of emotion. Other children like much more soothing, soft tones in order to relate to you and in order to be part of a relationship. So what works? And how good is the family? What is going on in the family with mommy and daddy and siblings that make it possible to do the things that work for that child? In other words, what are the family strengths and what are the family challenges? You have to ask yourself that honestly and again,




there is no better person to ask that than the family themselves because they know themselves better than anyone else. So if we can ask those four questions:

1. What are the problem behaviors?
2. What are the fundamental foundation pieces or building blocks or essentials – how is the child doing on those?
3. How is the child doing on the contributing processing capacities?
4. How is the child doing in terms of what the family can do; in terms of what works and what doesn't work and how much they are able to do the things that work for that child versus the things that don't work for that child?

Once we answer those four basic questions, we then begin to have an idea of what that child needs. Where does the work need to be done? How much work needs to be done on the behaviors themselves? How much work needs to be done on the fundamental foundation building pieces of relating, thinking, and communicating? To what degree do we need to strengthen the processing capacities? To what degree do we need to work on family issues so that families can do the things that work – overcome marital problems, overcome problems with other siblings, or financial problems that may be hampering availability to the child. And as we answer each question, we are identifying now the element that needs to be included in the comprehensive program.


So once we have identified the elements, i.e., in terms of goals: we need to work on the foundation pieces, we need to work on these processing capacities, we need to work on these types of family interactions, we need to work on these types of problem behaviors - now we can look at the range of interventions out there and see what is likely to help. Where can I get help for each kind of thing? Again, this is something that parents can assess because each intervention approach is very clear on what it tries to address. So for example, behavioral models, sometimes called ABA or Discrete Trial, are very clear that they want to address specific behaviors. Their goal is to work on teaching the child not to stare at the fan or rub the spot on the floor or beat themselves or to work on a specific skill like repeating a certain sound or identifying a picture with a sound or putting a certain block in a certain type of hole where that block fits. On the other hand, at the other extreme are relationship-based approaches where the goal is to build warm, nurturing relationships with the child, help the child learn to enjoy interacting and relating and learning intimacy of life. There are specific approaches, and those are called under the broad banner, Relationship-Based Approaches. There are also specific approaches developed by therapists with years of training to work on the different processing areas. So speech pathologists work on auditory processing and language –



taking in sounds and comprehending them, learning to understand and then also communicate back with words or symbols. Occupational therapists and physical therapists work on improving motor capacities and motor planning and sequencing so the child can take action on the world in an organized way. Occupational therapists also work on sensory modulation – helping the child regulate and modulate sensations. Mental health professionals work on family patterns and on helping families adapt to the child, to resolving marital problems, or resolving problems with other siblings or working out family patterns that work for that family. There are also professionals who are good quarterbacks – who can be what I call co-quarterbacks with the family, helping you put together a comprehensive plan for your child, helping you figure out how the elements can work together. There are professionals of different disciplines who do this. Some are mental health professionals who have been trained to put together comprehensive programs. Some may come from developmental pediatrics or pediatric neurology. So fields like psychology and child psychiatry and behavioral pediatrics and developmental pediatrics and pediatric neurology and social work, but also, some speech pathologists and occupational therapists have also become trained at putting together comprehensive programs by getting extra training in areas that they weren't originally trained in. So it is very important, if you can, to find a professional who can help you put together a comprehensive program.


Now it is also important to recognize that if you elect an approach that works on one area, like just changing behaviors, and the approach says that once the child stops banging their head or once the child stops being echolalic, all these other things will take care of themselves – the child will learn to relate, be spontaneous, be interactive – I would advise you to look at such a statement cautiously. I don't see that happening very often. In my own experience, you get what you practice. What goes in is what comes out. There are no secrets here. Children who learn something in a very structured, rote way tend to be able to give that back in a very structured, rote way. Children who learn to relate with warmth and pleasure and delight and excitement and a sense of humor tend to enjoy relating warmly with excitement and a sense of humor. So what goes in tends to be what comes out. So observe – not only read, not only listen – but observe approaches in action, and say “does this address what my child really needs? Where is the fundamental problem here?”

Now over the years, we have developed a model - a framework - to help parents and professionals create a comprehensive program to look at each of these elements. Now the model itself doesn't dictate the specific intervention, but does give you a more systematic way of addressing all the pieces I just discussed. We call this the DIR Floortime Model. This is different from the Floortime Intervention Model. The DIR



Model simply means: D – Developmental, and that’s for the functional developmental capacities, i.e., these fundamentals of sharing attention, engaging, purposeful communication, problem solving interactions, using ideas creatively, and using ideas logically. So those are the six developmental capacities – the fundamental building blocks that all children need to master to be healthy. And children with special needs especially need to master these if we are going to help them get onto a healthy trajectory. So that is the “D” part. The “I” part of our DIR stands for “Individual differences.” This is individual processing differences. These are the underlying building blocks or foundations for our essentials. These are our auditory processing and language, visual spatial processing – making sense of what you see, motor planning and sequencing – being able to organize your actions, and sensory modulation – being able to regulate and modulate your sensations. So that is the “I” part of the DIR. The “R” part stands for “Relationships.” This is the family relationships and learning relationships. This is the relationships that work for the child and understanding the relationships that don’t work for the child and trying to help the family, obviously, have those relationships that work for the child. Now, an added note on the relationships that work for the child, the relationships that work for the child, that help him strengthen his processing abilities and build higher and higher mastery of these essential building blocks we have been talking about, are relationships that are tailored to the child’s unique profile. In other words, if the relationships can be tailored to where the child is in his mastery of the essentials – does he need to work on basic relating or does he need to work on using ideas in an imaginative way or does he need to work more on thinking skills – asking him “why” questions, that relationship needs to be tailored to where the child is in terms of their developmental progression. Also, that relationship needs to be tailored to the way the child takes in information and acts on the world. Do you have to focus more on slowing down the sounds or being enthusiastic about the sounds? Do you have to focus more on adding a lot of visual support into the system? Do you have to focus on extra soothing or extra animation in the way you approach the child? Do you have to go and deal with just simple action sequences rather than more complex ones, or should you be working on more complex ones?

So tailoring means tailoring to the child’s functional emotional capacities, i.e., their essential building blocks of relating, thinking, and communicating, and tailoring to the way they take in information and act on the world, i.e., their processing capacities. When the relationships can tailor to that, then we can have the child basically improving and strengthening their abilities all their waking hours because all the time we are interacting with the child, we are actually strengthening the child and from the child’s point of view they are just having fun.



So that's our DIR Model. Our DIR Model is a way of analyzing these component parts. So within the DIR Model we sometimes recommend approaches that work on the relationships and the fundamental building blocks. We recommend approaches that strengthen the processing capacities. And we often recommend approaches that work on specific behaviors that help the child master specific behaviors.

I'm going to take a break for just one second, then I'm going to give you more examples. Hold on just one second. Ok, we're back. That was just a little break.

So the DIR Model helps us figure out how to create this comprehensive program, how to have elements in it that address the relationships, that address two-way communication, that addresses the creative use of ideas, that addresses the processing areas, and also addresses the family issues to help the family tailor the approach to the child and resolve family problems that may interfere with that, and also approaches that work on specific behaviors. So within the DIR Model, we may take pieces from many different programs. So I can give you an example of a comprehensive program that we may recommend from the DIR Model that addresses all the elements. You'll see it can include many specific interventions and that's the key – not to fit the child to the intervention, but to fit the intervention to the child. It should be different interventions that are integrated into a pattern for that child. So be leery of a one-size-fits-all approach. Be leery of only doing one thing when your child may have challenges in numerous areas.

Always embrace comprehensive approaches that address the fundamentals as well as the surface problems. Before I give you an example of a specific program, let me just break this down in another way for you. Frequently when we think about autistic spectrum disorders, we can think about the primary problems or the primary symptoms and the secondary symptoms. The primary symptoms have to do with problems in relating, thinking, and communicating. The secondary symptoms have to do with specific behaviors like repeating words or scripting or staring into space or looking at a fan. Now unfortunately, the secondary behaviors often get our attention because they are the ones that make the child look different out on the playground or in the restaurant if the child begins staring at the fan or yelling, and that's what embarrasses us all and so we want something that is going to change that right away. But, that's a little bit like treating the fever with aspirin, which can be helpful, but not treating the underlying pneumonia with proper antibiotics. You may get some little relief from the symptoms temporarily, but the overall condition may not improve. You've got to do both. And the interesting thing is when you work on the primary problems; the primary symptoms – the relating, thinking and communicating – the secondary symptoms often get better on their own as part of the process, or you focus on them as part of the comprehensive program. For

example, a child who is relating and learns to love to relate doesn't want to be self-absorbed anymore. A child who learns to communicate purposefully tends not to communicate in a chaotic way. A child who learns to take actions to solve problems and be a problem solver tends to not line up his toys because now he can use his toys to solve problems. He can build things with his toys. He can build houses and castles. A child who learns to do imaginative play tends to not just repeat the same theme because they enjoy their imagination too much. A child who learns to think logically tends to not script or be echolalic because now they can tell you what they want, when they want it, why they want it, and hold you to task if you don't do it quickly enough and even yell at you a little bit.

So each fundamental building block that resolves the primary symptoms tends to also by its very nature resolve most of the secondary symptoms. When they don't fully, we can then add on specific approaches that resolve the secondary symptoms. So you usually get two-for-one when you work on the primary concerns.


Now typically a comprehensive program would involve the following:

1. It would involve an active home program where we often recommend spontaneous play with parents where you are working on the six fundamentals – these basics that we have just talked about – attention, relating, two-way communication, problem solving interactions, creative use of ideas, and logical use of ideas. You're working on all those things together at the highest level the child can through just fun play; following the child's lead, doing what the child wants to do, jumping in, and getting it cooking. So for a child who is aimlessly wandering around the room, you might follow him around the room and sing together or dance together or you might start blocking his path so he has to go around you or you might even do what I call the "fence game" where you hold your hands around him but don't actually touch him and he has to lift your hands to get out from your fence and soon you are interacting and having fun together. Or for the child who is opening and closing the door, you get stuck behind his door and pretty soon he's got to order you out of his door and he's communicating and pointing and sometimes smiling and laughing. So we join the child's world, we bring you into our world, and we bring it to the highest level of these fundamentals, just through spontaneous play. We call that "Floortime." No matter what the approach and no matter what your philosophy is in life, and no matter what you have been told, you cannot help a child develop healthy and normally without this kind of play. Some people will call it differently. They may call it "fun" or call it "family fun" or may just call it "play." We call it "Floortime" because it is getting down on the floor with a young child. Whatever you call it, it has to be there. So my advice is, do not try to have a comprehensive approach that doesn't have this element in it as a significant component because children

can't learn spontaneity and the pleasures of thinking, relating, and communicating without it. So whatever else you are doing, you have to do a lot of this.

2. You need to do what we call "Problem Solving Interactions." These are semi-structured learning interactions. This is where you try to teach a child new words or new motor skills. We have developed in our own program, in our DIR Intervention Program as opposed to our DIR Method of Analysis, a particular curriculum for this. We have a curriculum for language called the ABLC – the Affect Based Language Curriculum. Other of our colleagues who also work within the DIR Model have developed their own language curriculums. If you look at our DIR website, you'll see different of the leading speech pathologists from around the country who have developed different approaches. The behavioral folk who practice ABA and Discreet Trial have approaches of teaching words. But we believe that those are too structured and too rote memory-based and don't do it in the way we want to see it done, which is in a more incidental or problem-solving way. So what is common to all the problem solving ways of teaching new motor skills or new language skills as the second part of the language program, is that we create learning situations where the child needs to solve a problem. If we want to teach the child to say the word "open" we put his favorite toy outside the door and if he's trying to pull on the door, we say, "should we op, op, op?" and if the child repeats "op" then we open the door and the child understands "open" as opening the door to get at the toy. So there is motivation. There is intentionality and meaning through the emotionality of the experience immediately. It's not looking at a picture and memorizing the word "open" and then learning to generalize it at the door. This generalizes it immediately. So we call that "problem solving learning" because it mobilizes the child's affect. This can be applied to the motor skills as well as the language skills. Again, we have different curriculum for the different areas. Some of the specific curriculum that we have that are very helpful are the Affect Based Language Curriculum, for visual spatial thinking there is a book by Harry Wachs called, *Thinking Goes To School* that is very helpful, and most occupational therapists can provide parents with home programs to work on motor skills. They can all be done as part of fun and games. We'll have a motor based curriculum out very shortly as well.


3. Once children begin to be interactive and once they can master the level of problem solving interactions, benefit from one-on-one play with peers – most children need at least four peer play dates a week in addition to whatever school activities they have. And it has to be with a peer who is interactive and can use some language so that the child is getting someone who is interacting back with them. Initially the parents will have to orchestrate the interaction and orchestrate the games. So that is another part of the home program, it's the peer play.



4. Some of the children benefit from the dietary and nutritional work and often consulting with a nutritionist who is expert in children with special needs can be very, very helpful in terms of figuring out a program that will work for your particular child. Again, the research on diet and nutrition is not definitive yet, so it has to be looked at from the point of view of the individual child rather than definitive guidelines for all children.

So those are some of the components of the home program. In addition, many of the children benefit from working on those processing abilities and having speech therapy and occupational therapy or physical therapy, and that can be a very vital part of their program. Within that, some of the children benefit from augmentative communication help where symbol systems or different other ways of facilitating the outflow, particularly if the child has motor planning problems, can be very helpful. Many of the children require educational programs, but here is where we can again, go awry if the educational program doesn't focus on the fundamental building blocks and also focus on the processing differences of the child. So some children need to be in a regular preschool with an aide or just in a regular preschool so they have access to children who are very interactive. That depends on the ratio and also the talents of the preschool staff. Often an aide may be necessary and helpful. Other children can be in a special needs classroom, but it's better for that to be an integrated class so that as the children become more communicative, there are communicative children to communicate back with. Occasionally you can have a completely special needs class when the child is working on their first levels of just learning to attend and relate and engage and purposefully interact very simply. But once a child becomes a complex multi-circle interacter, you'll have to have access to peers who can be very interactive back. The special needs class alone won't work as an educational setting. It needs to be an integrated setting where the child has an aide in a regular preschool. The education program, though, needs to also do the same things we described as for the home program – the spontaneous interaction we call Floortime, as well as problem solving interactions to teach new skills, but based on motivated learning, not rote learning.

Also, many children benefit from bio-medical approaches. Initially in the evaluation, you need to rule out even subtle seizure problems and some of the children need the 24 hour EEG to rule that out, particularly children who have had regressions in their development. Allergies need to be assessed because they can affect behavior and affect thinking skills. Medical problems that might contribute such as thyroid or other hormonal problems need to be looked for by the pediatrician or by specialists. For some children, GI problems may play a contributing role and need to be looked for. The child's




reaction to environmental substances and again, I mentioned allergies or allergic reactions or any types of auto-immune reactions need to be looked for.

Also, some of the children do have serious problematic behaviors that may be worrisome. If the overall approach is not helping them in terms of those behaviors, in other words if they are doing something that is self-injurious, for example, or doing something which makes it hard for them to relate and interact and the improvement in relating, interacting, and thinking isn't offsetting it, then we may want to do some analysis of their behaviors to figure out what might be maintaining those behaviors. There is a difference between behavioral analysis – trying to look at what is supporting the mal-adaptive behaviors from a discrete trial or an ABA-type intervention program which uses a very structured program of focusing on changing behaviors but not working on these fundamental building blocks quite in the way I'd like to see. So behavioral analysis can be a part of the program. For some children we have included behavioral principles as part of a comprehensive program for very narrow areas of learning where we do that briefly to help a child master a certain set of behaviors, but it's part of building these foundations and these building blocks. So as part of a comprehensive program, we can include many different elements: the traditional therapies like speech, occupational therapy, physical therapy, educational approaches, but it has to have a very active home program and we can include elements of behavioral approaches to work on specific behaviors or analyzing what is maintaining these specific behaviors in the environment.

But the idea is, and the whole concept is, to know your child first. Know how your child is unique and different. Know how your child attends, relates, communicates, and thinks. Know how your child processes information – auditory and visual. Know how your child plan actions. Know your family's strengths and weaknesses. Then play your program accordingly. Sounds like a tall order. It is a tall order, but nothing short of it will work. And that's the fact. So we have to deal with a complex problem with a complex approach. Seeking out something that seems simple where we don't have to take much responsibility as parents, where we don't have to be co-quarterbacks just simply won't work for complicated problems. I find that parents are the experts, they do know their children best, and don't feel like you have to do something overnight. This is a gradual approach, work with professionals who will work with you, and over a period of time, everyone can construct a comprehensive program.

It need not be expensive. I mentioned OT and speech and PT and educational approaches. Sure, we want the ideal program. But the heart of the program is the home program; what parents can do themselves. And if it is too expensive and the school system or insurance won't support specialists, then I recommend parents read *Implement the Home Program* and use the specialists as consultants rather than as weekly or multi-



times a week therapists. So you can see the occupational therapist or speech pathologist periodically, even every few months, to guide you in your home program in terms of the semi-structured problem solving components. You can have a person trained in the Floortime components to guide you periodically in those components. And the lion-share of the program can be carried out at home. If the school system can't provide what you need and want, then you can consider home schooling. The key thing is to make sure you are addressing the needs of the child. Now we have written a book called, *The Child with Special Needs* that outlines this approach, and it should be available in most places where books are available.

So we are almost finished with our show for today. I didn't have time to address questions today because I wanted to be comprehensive and deal with this most important topic, but what I talked about today is really what I get asked most and this is really the essential information that all parents need to have.