



# **The BEST PRACTICES**

Newsletter  
Of

*The Interdisciplinary Council on  
Developmental & Learning Disorders*

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*The Best Practices Newsletter of the Interdisciplinary Council on Developmental and Learning Disorders is written to provide regional updates and networking opportunities to professionals and parents working with young children with communication and relating challenges. We hope to provide information and support and welcome any feedback or contributions that you may have. Please address your comments to Jo Raphael, MSW, Editor at: 3213 Midfield Road Baltimore, MD 21208, E-mail at [JO@ICDL.COM](mailto:JO@ICDL.COM), phone or fax at (410) 486-1251. Thank you.*

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*Editor's Note*

Jo Raphael, M.S.W.  
Molly Romer Witten, Ph.D.

Dear Readers,

This is an exciting time for all of us as we enter 2004. At the ICDL conference in November 2003 we learned of many interventions, research projects and innovative treatments that are happening all over the world. Creative clinicians, educators, parents and scientists are exploring and improving outcomes for those with communications and learning challenges. Adding to our excitement is the launching of the Floortime Foundation. This wonderful new group was started to increase awareness, access and education of the DIR/Floortime model. David Raphael, founding Executive Director shares his vision with us.

We will provide summaries of some of the panels from the annual conference with you in this and future issues of the Best Practices Newsletter. In this edition there is a wonderful summary of: *Becoming Friends: Innovative Models for Facilitating Social Interactions with Peers for Children with ASD and Other Developmental Challenges*.

Make sure to read the beautiful poetry and an informative article on Sensory Motor Integration.

Your feedback is important to us. Please write to us to post information, to submit an article for consideration or to share your thoughts. Please send us contributions for consideration for publishing.

You can reach us by e-mail at (Molly) [besobeso@enteract.com](mailto:besobeso@enteract.com) or (Jo) [jo@icdl.com](mailto:jo@icdl.com).

Best regards,

*Jo and Molly*



## **The Floortime Foundation**

David Raphael, Executive Director

It is remarkable how similar our stories are. We began our journeys with all the hope and joy that the birth of a child brings. At first there was a shadow of suspicion and concern. Something about this child was different. Maybe it was the arching of the back, the refusal to put on socks or gloves, a lack of responsiveness. As the concerns grew, perhaps because our child was not speaking, perhaps because he or she didn't seem to know how to play, we spoke with our pediatricians. They reassured us: "It's too early to be concerned", "boys are different", he'll grow out of it". But he didn't and our concerns grew till we became alarmed. Finally, at the recommendation of a pre-school teacher, or because we knew in our heart of hearts that something was wrong, we had our child diagnosed. What we were told took our breath away: Autism, Pervasive Developmental Disorder. We were given a label we didn't understand and a prognosis that offered little hope. In our case we were told that our son was probably retarded and would have to be institutionalized. I have heard other parents say that they were told that their child would never be able to love them.

For many of us, this began a journey that lasted months, even years. We searched the web, spoke with specialists and tried different programs. In the midst of our anguish in searching for an answer we battled with school systems and insurance companies.

Then, for a small select group of us, a miracle happened – we found our way to a DIR/Floortime clinician. And, sometimes within the space of a one-hour session, we were given new hope. We began a DIR/Floortime-based program and we often saw remarkable progress. Our lives and that of our children were open to new possibilities, new potential and new hope.

For many of us, connecting with a DIR/Floortime clinician was a remarkable quirk of fate. For others, it involved

hundreds of hours of research and investigation.

Only once we initiated a DIR/Floortime-based approach did we realize the extraordinary commitment of time, energy and funds we had undertaken. Some of us were in positions to sustain that level of funding and energy. For others, it was a burden we found difficult to bear.

This shared sequence of frustrating and often painful experiences along with the reality that the vast majority of parents will not have knowledge or access to the DIR/Floortime methodology compelled us to establish the Floortime Foundation. We believe that the DIR method can, in the words of Dr. Stanley Greenspan "redefine the potential of children with developmental and learning challenges"

It is the vision of the Floortime Foundation that within ten years:

1. The DIR/Floortime approach will become the recognized method of choice for treating children with developmental and learning disorders.
2. A multi-disciplinary DIR/Floortime-based treatment approach, led by certified professionals, will be available to all parents and children regardless of their location or socio-economic class.
3. The average time it takes from when a parent reports to a primary care pediatrician that he or she fears that his or her child has a serious developmental and learning disorder to when a DIR/Floortime-based treatment approach is initiated will be reduced to 90 days.

The Floortime Foundation has established the following goals for the next years:



1. To promote awareness of the Developmental, Individual, Relationship-based (DIR)/Floortime approach to treating children with social and communication challenges
2. To promote early identification for children with social and communication challenges and early intervention in quality, DIR/Floortime-based programs
3. To educate clinicians, educators, parents and child care providers in DIR/Floortime-based theories, techniques and trends.
4. To dramatically increase access to quality DIR/Floortime-based programs and well-trained DIR/Floortime clinicians and educators serving children and adults with social and communication challenges

In order to achieve these goals, the Floortime Foundation is pursuing the following strategies:

**Awareness:** Through an array of media, the Floortime Foundation will broadly promote awareness of the growing numbers of children being diagnosed with developmental and learning challenges. It will disseminate information regarding the new treatment modalities and educational opportunities available for these children and their families. Web sites, publications, resource guides will be key elements of a broadly developed media approach

**Early Intervention:** Early intervention is a critical element in promoting more favorable outcome. A broadly developed information campaign will enable parents, primary care

pediatricians and child care providers to more quickly identify the early signs of developmental and learning challenges and pursue treatment opportunities.

**Education:** Floortime Foundation will develop an array of training opportunities so that thousands of individuals have access to D.I.R. training ranging from basic instruction to advanced clinical training. Key to the success of these efforts will be the creation of a core of highly trained clinicians to provide training, supervision and mentoring. In addition, regional training conferences, distance learning and computer-based training programs will promote the development of core skills in thousands of clinicians, educators and parents. Ultimately, the Floortime Foundation will work in close partnership with ICDL to create university-based degree granting programs.

**Access:** Every child and every family deserves to have access to highly trained clinicians and educators and quality programs. The Floortime Foundation will promote the development of community-based programs and services for children with developmental and learning challenges through organizational assessment and consulting, scholar-in-residence programs and organization-based training programs.

I invite you to be our partner as we build the Floortime Foundation and seek to advance the DIR/Floortime approach. I welcome partnership along with your thoughts, guidance and advice. We have begun an exciting journey filled with hope and opportunity. I hope you will join us.

[www.floortimefoundation.org](http://www.floortimefoundation.org)

## **Sensory-Motor Integration**

Parviz Youseffi, Ed.D.

Arousha Youseffi-Shahin, M.S. Ed.

**Editor's Note:** *Sensory-Motor Integration, as developed by Dr. Parviz Youseffi, should be distinguished from Sensory Integration Therapy which may have many similarities but has its own distinct theory and set of practices.*



### **Concept**

Sensory-Motor Integration (SMI) can be best described as a multi-sensory approach to addressing learning needs of children who have been diagnosed primarily with developmental delays, Autistic Spectrum Disorders, hypotonia, motor delays and apraxia. By incorporating methodologies of sensory integration and motor development, the SMI approach enables children with special needs to sequentially and successfully acquire motor capabilities and motor planning. Our program builds upon two very key elements:

1. Sensory integration as a means to regulate and network the nervous system.
2. Motor development as the vehicle to achieve physical, cognitive, neuromuscular, body and space capabilities.

### **Sensory Systems**

All the information we receive about the world comes to us through our sensory systems. Because many sensory processes take place within the nervous system at an unconscious level, we are not usually aware of them. Although we are familiar with the senses involved in taste, smell, sight and sound, most of us do not realize that our nervous system also senses touch, movement, force of gravity and body position. All sensory systems have receptors that pick up information to be perceived by the brain. Receptors within our skin detect information about light touch, pain, temperature and pressure. Structures within our inner ear detect movement and changes in the position of the head. Components of muscles, joints and tendons provide an awareness of body position.

### **Movement**

The more closely we evaluate the intricate functions of the brain and body, we can only come to a certainty that movement is essential to learning. Movement awakens and activates many of our mental capacities. Movement integrates and anchors new information and experiences into our neural networks. The sense of movement involves the interacting of two main sensory apparatus, the vestibular and proprioceptive systems. The vestibular system responds to

body movement through space and change in head position. It automatically coordinates the movements of one's eyes, head and body. If this system is not functioning well it is impossible for a student to look up at the blackboard and back down at their paper without losing their place. It is difficult to walk on escalators without fear, or balance on one foot long enough to kick a soccer ball. Closely related to the vestibular system is the sense of proprioception, which gives us an awareness of body position. When proprioception is functioning efficiently an individual's body position is automatically adjusted to prevent falling out of a chair. Proprioception also allows objects such as pencils, buttons, spoons and combs to be skillfully manipulated by the hand.

### **Motor Development**

The earliest patterns of motor behavior appear to be genetically coded in a species; that is humans have some initial organization or template that guides the pattern of new formations. At birth babies have no voluntary control over movement. The baby responds to sensation through the primitive reflexes. There are automatic stereotyped movements mediated by the most primitive part of the brain, the brain stem. Their job is to control basic survival functions necessary for the first few months of life. As the infant grows, so does the central nervous system. Higher more sophisticated regions of the brain begin to supersede primitive reflexes. As this occurs early survival patterns are inhibited or controlled to allow more mature patterns of response or postural reflexes to develop in their place.

When postural reflexes replace primitive reflexes the infant begins to gain control of its body and body movements. Later on, movement patterns are played back and adjusted to meet the demands of the task being performed. Some children fail to gain this control fully in the first six months of life, and continue to grow up in a reflexive mode, where some of the primitive reflexes remain present and the postural reflexes do not develop fully. These children have enormous difficulty with voluntary movement patterns as the body remains under the influence of involuntary response. Retained



primitive reflexes will also affect a child's sensory perceptions, causing him or her to be hypersensitive in some areas and hypo-sensitive in others. If both sensory input and motor response are impaired, conceptualization of certain movements becomes impossible! This can affect not just arms and legs, but eye functioning, visual perception, balance, and the processing of auditory information. Fortunately retained reflexive activity, which is indicative of poor sensory motor development, can be detected at an early stage. As a child grows, expectation of more mature movements increases proportionally. Movement becomes symbolic of life and existence. Movement is the sole manner of *physical* expression and intelligence. Similar to building blocks, there are graduated levels of motor development and motor planning. Children should be exposed to specific patterns at a given stage of development. If a child misses a critical developmental stage, if they lack the link from one pattern to the next, they will show evidence of problematic motor performance.

### ***Motor Planning***

Not only does sensory motor integration allow us to respond appropriately to incoming sensations, it also guides the way that we act in the environment. For example, motor planning is an important ability that depends on efficient sensory integration. Motor planning involves having an idea about what to do, planning an action, and finally executing the action. New actions are planned using knowledge of past experiences and the sensations that accompany them. The tactile, proprioceptive, and vestibular senses are particularly important in providing knowledge about how the body moves and how it can be used to act on the environment. When motor planning occurs, a person is able to deal with a completely new task by organizing a new action. Motor planning involves conscious attention to the task while relying on stored information regarding unconscious body sensations.

### ***Sensory-Motor Integrative Disorders***

For most children sensory-motor integration develops in the course of ordinary childhood activities. Motor planning ability is a natural

outcome of the process as is the ability to respond to incoming sensation in an adaptive manner. But for some children, sensory-motor integration does not develop as efficiently as it should. When the process of sensory-motor integration is disordered, a number of problems in learning, development, or behavior may become evident.

### ***Signs of Sensory-Motor Integrative (SMI) Dysfunction***

Not all children with learning, developmental or behavioral problems have an underlying sensory or motor integrative disorder. There are certain indicators, however that can signal a parent that such a disorder may be present. Typically a child with SMI will show behaviors in more than one area. Observations of the child need to be made when he/she is motivated and fully engaged in a dynamic, pleasurable activity. At that time the observer can assess the child's responses in the areas of physical fitness, perceptual functioning, static and dynamic balance, eye hand coordination, visual motor perception, haptic organization, motor planning, fine motor control, cognitive and reflexive activity.

### ***Evaluation***

If you suspect that your child fits this picture, for example, if they are unable to execute intentional actions, sensory-motor integration specialists can conduct an evaluation. Results of the evaluation will indicate whether or not a sensory-motor integrative disorder is present and will provide you with a profile of your child's sensory processing abilities in a number of cases.

### ***Therapy***

In therapy, your child will be guided through enjoyable activities that challenge his/her individual ability to respond appropriately to sensory input, by making a successful, organized response. Therapy will involve activities that provide vestibular, proprioceptive and tactile stimulation as well as perceptual and cognitive tasks designed specifically to meet the needs of each child in an interactive and reciprocal way.



## ***Contributions from Our Children***

Editor's Note: This is a new column created to share the beautiful thoughts and artwork of children with disorders of relating and communicating and their siblings. Please send contributions for consideration for publishing to: [Jo@icdl.com](mailto:Jo@icdl.com). Thank you!

### ***The Record of my Life***

NRR-age 16

Born yellow, chicken legs, they used to call me.  
There was one above me, Eskimo, they used to call her.  
Then one more came, the loud one, they used to call him.  
Except, this one, everyone called

Different.  
Different.  
Different.  
Different.

They saw him as a threat because he was

Different.  
Different.  
Different.  
Different.

He's not a normal boy, he will never be a normal boy, because he is

Different.  
Different.  
Different.  
Different.

"He just can't be the same".

We went everywhere, met everyone, but they all told us the same thing. We were almost convinced that he was

Different.  
Different.  
Different.  
Different.

Then things changed, finally somebody told us something else than

Different.  
Different.  
Different.  
Different.

He was special, amazing, brilliant, he could learn, he would learn. It was

Beautiful.  
Beautiful.  
Beautiful.  
Beautiful.



**Summary of Part I of Panel Presentation:**

ICDL Annual Conference – November 2003

***Becoming Friends: Innovative Models for Facilitating Social Interactions with Peers for Children with ASD and Other Developmental Challenges***

Michele Havens, Ed. D.

The Roots of Cognitive-Social Strength in the Early Years: Reverberations in Peer Interaction in Children with Developmental Challenges

Presenter: Lorraine McCune, Ed. D.

The Art of Guiding Children's Socialization and Imagination: Integrated Play Groups Model

Presenter: Pamela J. Wolfberg, PH. D.

Why is this child alone? Dr. Wolfberg asks us to observe a child on his own on the playground. Look at his affect. Other children are playing all around him. Did he choose to be alone? Did he try to initiate and get rejected? Do the other children think that he's weird? Is he waiting for someone to join him? Did he choose to be alone? Children need tools to be able to play and interact successfully. Children on the autism spectrum often do not have these tools to use for complex language or social interaction, without direct instruction.

Play and language develop concurrently between the ages of one and two years old, along with their ability to pretend. Looking at a child's level of play, one should be able to determine their language level; this is not always easy. For many children, verbal language lags behind play development. It may be that what is important about language and learning is what's on our minds; it is possible to have language, without having the words. This connection between language and play is critical.

Dr. McCune studied language development in young children aged 9-16 months and discovered that both verbal and non-verbal children used grunts for several functions, effort, attention and communication. All primates use grunting for communication. The underlying notion of the grunt is that a child learns that sound has meaning. The grunting is reinforced by parents, which builds on attunement and reciprocity.

In order to develop language skills, the necessary components include: relation to others, experiencing and expressing meaning without words (grunts, gestures), phonetic ability to make sounds, experiencing and understanding word meaning (names for people, things and actions), and representation of meaning. In order to have a word for an object or action, a mental representation is necessary. This holds true with representation in play. The child who holds an empty cup and pretends to drink, is demonstrating that they understand the concept of drinking.

Pretend play develops through the following stages: taking on a single role (feeding a doll), follow a play sequence with a passive partner (feed doll, put doll to bed), sharing a role with another child (two mommies feeding two dolls), playing a role in a relationship (one child is the mommy, one is the baby) and sharing roles in sequence (both are mommies, both are babies). Children need peers to play with and model from. One child starts the play, the other watches, then joins.

Pretending teaches about reality and how to practice coordinating interaction with others (when it doesn't matter!). It teaches a child how to be a partner, or a recipient in communication, as well as, how to control a situation. Pretend play themes allow for expression of language and meaning. Children at play are operating from a model



of experience; all children know about eating, sleeping, etc.

Social challenges of children with ASD include difficulty in establishing age appropriate and/or developmentally appropriate peer relations. Due to deficits in joint attention and emotional reciprocity, there is a lack of spontaneous sharing of interest and enjoyment. Children with ASD do not generally show a strong ability to imitate, a skill critical to developing appropriate play.

The overall play styles of children with ASD fall into three categories: aloof-withdrawn, passive, and active-odd (from the work of Wing & Gould, 1979). When more closely examining the symbolic dimensions of the play of these children, manipulation or sensory play is the most commonly observed. Within this type of play, there are fewer different actions observed, involving stereotypic routines from simple to complex. The children tended to direct their play toward objects rather than dolls. Symbolic play was the least common form of play observed, with less diverse play schemes and fewer novel acts observed. Play scripts were rigid and inflexible, tending to be repetitive in nature; the children were not able to attribute mental states to others (dolls or another person).

Since play does not develop spontaneously for children on the autism spectrum, Dr. Wolfberg developed a model of teaching socialization skills, as well as play and imagination. She used the concept of Integrated Play Groups (IPG), small groups of children with Autism Spectrum Disorder (ASD) and typical peers or siblings who meet and play together regularly with facilitation and guidance from a trained adult. Children with ASD are known for their challenges in social and play development. The IPG model allows for continued and supported development of these children's social interaction, communication, play and imaginative skills.

Participation in an IPG begins with an assessment of play and language skills in social play, play style and preference, and social communication ability. The children are then placed in groups of 3-5 students

(preschool/elementary), with a higher ratio of expert to novice players. Typical peers make up the group of expert players, while children with ASD, as well as other developmental disabilities are included in the novice player group.

Structured play sessions consist of an opening ritual (greetings, planning of activity), guided play, and a closing ritual (clean-up, planning for next session, snack). Play initiations are monitored and guided, play is scaffolded with the appropriate level of adult support (maximum to minimum). Social communication guidance is provided with cues given as to what to say and do in various situations. Visual and auditory support is given.

Groups meet twice a week for 30-60 minutes and run for a 6-12 month period. Each group is individualized to meet the needs of the members. Adult support is faded as the skills level of the group members increases. On-going research has demonstrated the benefits of this intervention for children with disabilities in the areas of social communication and play, as well as increases in related representational ability (drawing and writing). All participating students have shown benefit in the formation of friendship with peers.

Play has an important role in childhood. It reflects and leads development in cognition, social competence, language, affect, creativity and sensory motor. It is flexible and changing, and must be fun. Play is a universal phenomenon and a human right for all children. Play is the most valued social activity of childhood. For children with ASD, it is a path to inclusion with typically developing children.

Wing, L. & Gould, J. (1979). Severe impairments of social interaction and associated abnormalities in children: Epidemiology and classification. *Journal of Autism and Developmental Disorders*, 9, 11-29.



## ***Book Review***

Jo Raphael, MSW

*The Boy Who Loved Windows:*

*Opening the Heart and Mind of a Child Threatened With Autism*

By, Patricia Stacey

Perseus Books 2003

*The Boy Who Loved Windows: Opening the Heart and Mind of a Child Threatened With Autism* by Patricia Stacey is a wonderfully rich, poignant book that is compelling and beautifully written. As a parent and a clinician working with children and families on the autism spectrum I have come to know and work with many children and their families. This book gives a clear picture describing the components that make up the autism spectrum and gives hope to all of those who are diagnosed.

Ms. Stacey describes what happened with her own son and family in beautiful prose while giving clear, practical information on how to help and work with all children. We need to follow their lead, encourage them to be engaged with us and help them to grow using the developmental model. The method that Ms. Stacey chose to use with her son (Developmental, Individual Difference, Relationship Based) helped him to engage, attend and enjoy relationships and the world around him.

I find that this book is many things. It is mostly about possibility for change and growth. The hopelessness and despair that parents feel upon having their fears confirmed can be, and often is devastating. When a child is diagnosed with having an autism spectrum disorder it affects the whole family system. In many areas of the country

older intervention methods are relied upon and people are not aware that newer methodologies exist-let alone work. Ms. Stacey gives her readers many gifts in her book. She gives clear information on Sensory Integration, Autism Spectrum Disorders, courage and hope.

Ms. Stacey's book is not about shunning the autism community or those on the autism spectrum. Stanley Greenspan, M.D., puts it beautifully when he talks about working with those with communication and learning disorders-"redefining potential". It is about giving hope and help and that there is potential for each child on the spectrum-and that each of us can do better, can climb the developmental ladder and be more comfortable within ourselves, in the world and with one another. This is the message that comes through in the book and it is an amazing gift to readers.

This book is a must read for parents, family, friends and professionals. Whether you know someone on the spectrum or not, you will gain a new level of understanding on what it is like to live the life of a parent of a child with autism, what a child with autism means to the family and community and that there are wonderful new interventions available to help the child (or adult) to change and grow in a positive way.



## PUBLICATIONS

### ICDL Training Videotapes on the DIR Model and Floor Time Techniques

This 13 tape series, nearly 20 hours in length, features Stanley I. Greenspan, M.D. and Serena Wieder, Ph.D. demonstrating the Developmental, Individual Difference, Relationship-Based (DIR) model and Floor Time strategies for different types of children and families with special needs. Included with the videotapes is a guide highlighting what to look for in each of the tapes.

**\$530 members, \$585 non-members.**

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### Clinical Practice Guidelines: Redefining the Standards of Care for Infants, Children, and Families with Special Needs

For professional, parents and others concerned with improving the care of children with developmental and learning disorders. The Guidelines are available on our website, [www.icdl.com](http://www.icdl.com) and for purchase.

**\$35.50 members, \$42.50 non-members.**

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### The Functional Emotional Assessment Scale (FEAS) For Infancy and Early Childhood: Clinical and Research Applications

By Stanley I. Greenspan, M.D., Georgia DeGangi, Ph.D., OTR  
& Serena Wieder, Ph.D.

A systematic in depth approach to assessing emotional functioning during infancy and early childhood. It enables clinicians, educators and caregivers to assess the child's functional, emotional, developmental level and create a treatment plan based on the child's individual profile and measure their progress. The FEAS not only delineates the emotional functioning of the infant and child but captures the richness of the interactions between the child and his or her caregivers.

**\$39.50 members, \$47.50 non-members.  
Additional Protocol Booklets are \$8.00 each.**

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### For Parents by Parents

A resource guide for parents and professionals to aid parents as they search for assistance for their special needs children, written by The Parent Steering Committee of The Interdisciplinary Council on Developmental and Learning Disorders (ICDL). Information is presented in seven tabbed sections: Overview, Therapeutic Approaches, Biomedical Interventions, Sensory Processing, Educational Interventions, Law and Advocacy, and Glossary.

**\$19.00 members, \$22.00 non-members**

**Membership information and publication order forms are available at [www.icdl.com](http://www.icdl.com)**

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**All prices include shipping within the continental U.S. For shipments outside the continental U.S., contact ICDL for additional charges.**

### The Affect-Based Language Curriculum (ABLC): An Intensive

#### Program for Families, Therapists, and Teachers

By Stanley I. Greenspan, M.D. and Diane Lewis, M.A., CCC/SLP

An innovative approach to the development of language that integrates the affect-based model of human development, developed by Stanley I. Greenspan, M.D. (e.g. the Floor Time Model), with the development of receptive and expressive language, imitation, pragmatics, and engagement. The curriculum incorporates the principles of Systematic Instruction and Applied Floor Time as the primary teaching strategies. It also includes supplemental oral motor and augmentative communication techniques that support the development of language.

**\$42.00 members, \$47.00 non-members**

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### The Core Deficit in Autistic Spectrum Disorders

The 2002 special issue of the *Journal of Developmental and Learning Disorders*, with articles by Simon Baron-Cohen, Ph.D., Christopher Gillberg, M.D., Peter Tanguay, M.D., Nancy Minshew, Ph.D., Andrew Zimmerman, M.D., Barry Gordon, M.D. and Stanley I. Greenspan, M.D.

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### Early Indicators of Autistic Spectrum Disorders and Related Challenges

The 2002 issue of the *Journal of Developmental and Learning Disorders*, with articles by T. Berry Brazelton, M.D., Joshua Sparrow, M.D., Philip Teitelbaum Ph.D., Stanley I. Greenspan, M.D., Stuart Shanker, D. Phil. And Lonnie Zeltzer, M.D.

You can read both issues of the Journal on the ICDL website, [www.icdl.com](http://www.icdl.com). Hard copies are available from ICDL.

**\$42.50 members, \$45.50 non-members**

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### The Psychology of Global Interdependency; A Framework for International Collaboration

By Stanley I. Greenspan, M.D. and Stuart Shanker, D.Phil.

An examination of the new psychological challenges created by our growing interdependency, with a series of practical suggestions that will enable groups to work together to preserve civilization and create a future of peace and cooperation.

**\$15 members, \$19 non-members**

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### Bipolar Patterns in Children: New Perspectives on Developmental Pathways and a Comprehensive Approach to Prevention and Treatment

By Stanley I. Greenspan, M.D. and Ira Glovinsky, Ph.D.

A developmental bio-psychosocial framework for the early identification, assessment, preventative intervention, and treatment of children with bipolar patterns.

**\$30.00 members, \$35.00 non-members.**



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