

Web-Based Radio Show

Redefining the Standards of Care Part II: Answers to the Toughest Questions

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Good morning. This is Dr. Greenspan joining you and thank you for joining us on our weekly web-based radio show. Today we have a very interesting show because we're going to answer questions and we've taken the most difficult questions we could find about the DIR/Floortime approach. So, from all the questions you've asked and all the questions actually that we could think of that we've been asked over the years at various conferences and meetings, we've put together a list of the toughest questions possible. So, the title for this today is "The Toughest Questions That We Can Come Up with and You Can Come Up with About the DIR/Floortime Approach."

The first one we started with last week, but for those who weren't in on the show last week, we'll briefly go over it again, but the longer-winded answer is in last week's show. The first one is, "What evidence is there that the DIR/Floortime approach works?"



- What evidence is there (besides anecdotal) that the DIR®/Floortime approach works?

- What studies have been done or are being pursued?




We really have a number of sources of evidence and I say this, also being mindful that no evidence is ever complete and the most important goal we have is to do further studies.

We're planning a large clinical trial study, which is a more definitive study where we'll have random assignment of children to different intervention groups and be able to tease out exactly what's unique and special about the DIR/Floortime approach. What we believe is unique about it, based on existing studies where we have considerable evidence already, is that the DIR/Floortime approach works on the core deficits of autistic spectrum disorders. By the core deficits we mean the essential capacities that children need to learn to relate, communicate, and think and the capacities that are compromised in autism, but also other developmental disorders that interfere with relating, communicating, and thinking.

So, these core capacities or core deficits – they're two sides of the same coin – have to do with shared attention and engagement and back-and-forth emotional signaling or reciprocal interactions, as it's called. It has to do with what we call “shared social problem solving,” a continuous flow of back-and-forth interactions, sometimes also referred to as “joint attention.” It also has to do with using ideas creatively – creative thinking – and then using ideas logically and progressing to higher levels of logical and abstract thinking so you can get to the point where you make inferences and where you can see subtleties in your causal thinking, and where you can actually reflect on your own thoughts – think about thinking. It used to be thought that children with autistic spectrum disorders were not capable of these higher levels of abstract or reflective thinking, or even creative thinking, or even understanding the emotions of other people, in terms of empathy or emotional signal reading. We have lots of evidence now that with the DIR/Floortime approach a subgroup of children – and it's a fairly sizeable – in the 200-case study that I did, which was not a random sample or a representative sample, the majority of children achieved these high levels of reflective and creative thinking.

So the evidence that we have is from a couple of sources: One, we did an extensive chart review of 200 cases showing that the majority of children were capable of making progress thought unattainable in the past and we believe the reason why the children, or at least a subgroup of children, made this progress was because we worked on the emotional interactions as a foundation for creative and reflective thinking, rather than just trying to teach surface memory skills or just trying to change surface behaviors.

We also have evidence from a study that's not yet been published, but was presented at the meetings and will be published shortly, where we looked at children in




the short term, when we worked with them getting their emotions going in terms of following their lead, working with high levels of affect and motivation, and facilitating interactions that way and then using that as a basis for increasing language and thinking skills. We saw even in the first sessions significant differences between the first half and the second half of the session, showing that the children actually had the capacities for higher level interactions and thinking, but they weren't being brought out because the affect or emotional interactions weren't being worked with. Then we showed in the short term, and over the course of a year or two, there were significant statistical differences between the children's abilities at first, and then as it progressed. We used our functional emotional development scale to ascertain these differences.

Also, in a community-based application of the DIR/Floortime Model, Rick Solomon in Michigan looked at changes occurring pre/post in a large group of children using a home intervention model where had visitors trained to train families to work with the DIR/Floortime model in their homes, and it showed very significant statistical changes between the children before and after they had this approach in a large base community population.

Also, and very compelling, is the fact that we look at the components of the DIR/Floortime model because, remember, in this model we orchestrate speech therapy and occupational therapy and the home Floortime program, and work on visual-spatial processing and, if needed, biomedical interventions and nutritional interventions. They're all orchestrated together under the DIR model. The DIR Model is simply an analytic model where we figure out how all the pieces can work together and be tailored to the child's unique makeup or unique nervous system. When we looked at each element in the DIR Model – and we do that review in a chapter in our Clinical Practice Guidelines by Elizabeth Tsakiris, which is available on our website www.icdl.com, when we did that we found that there was compelling evidence for each element in the DIR Model. We work on the motor system, work on the language system, work on social skills and when we put it all together there are a large number of studies supporting the elements that come together under what we call a DIR approach.


Furthermore, in looking for further evidence that this approach not only works, but makes theoretical sense and is the best way to understand children, we recently have collaborated with the Psychological Corporation and Harcourt Assessment, Inc. They did a big field trial with hundreds and hundreds of children looking at our Functional Emotional Assessment Scales (FEAS), the parent questionnaire version of that is now called the Greenspan Social and Emotional Growth Chart. In that growth chart we looked at the different levels that need to be worked with in the DIR/Floortime approach, that is, shared attention, engagement, back-and-forth emotional signaling, shared social



problem solving, and creative and logical thinking. We found that children who mastered these abilities in the parent questionnaire – as according their parents – were developing as expected. Children who had challenges in these areas had various developmental problems, so that these variables or these processes that we feel are so important in the DIR Model distinguished children developing well from children who were having developmental problems. Furthermore, we found it was true for every disability we looked at – we looked at eight to ten different disabilities, from autism to Down’s Syndrome to Fetal Alcohol Syndrome, etc. Furthermore, we then looked at the relationship between mastery of the emotional interaction levels before pre-symbolic levels that lead to language that we postulate when we strengthen these, it leads to better language and better symbolic thinking. We looked at the relationship between those levels and the levels having to do with language and symbolic thinking and logical thinking and we found strong correlations, that is, the stronger the earlier levels of emotional signaling, which is so critical to our DIR Model, the stronger the language levels. Furthermore, we then looked at changes when we worked with children and we changed the early levels – does that lead to changes in language and symbolic thinking – and we found strong correlations that when you change the basic levels of emotional interaction and signaling we got stronger language and stronger symbolic thinking. So that also further supported our DIR/Floortime Model.

Now we have evidence from a naturalistic field study, as well as clinical intervention studies, that this approach not only is helpful to children, but that it also in a sense explains and helps us understand how children function, so it provides a framework for yet newer and even more innovative interventions in the future, because it provides an understanding of how the mind works and how the mind grows and develops. That’s really what’s important about the DIR/Floortime approach: It’s not limited to a “one size fits all” one type of intervention. It’s a model and a framework for understanding how to tailor interactions to the child’s growing nervous system and the child’s growing mind, which means tailoring it to the child’s – what we call – functional developmental level – and the individual ways they process and take in information and that this, then, leads to favorable development. We’re always developing better strategies and better ways to do this, so it’s a dynamic, living system that’s constantly improving and it can incorporate the advances from colleagues who are developing insights about better ways to help children be emotionally interactive and problem solve with us and learn to think creatively and abstractly.

So, that’s another long-winded answer to the first question, but I think it’s important to emphasize because this comes up in many different formats. So, the best way to think about DIR/Floortime is as a model and a framework that can organize a



comprehensive intervention approach. But what distinguishes it and makes it unique is that it focuses on the core deficits or core fundamental building blocks of relating, thinking, and communicating and it can organize a range of approaches, including the teamwork we need to work with children who have challenges in many areas, such as speech therapists and occupational therapists and physical therapists, as well as Floortime practitioners and coaches.

Now, “What studies are being pursued?” is the second question.

As I mentioned, we’re planning and have already written up an organized study for a clinical trial where we’ll compare DIR/Floortime comprehensive approaches with other existing, well-used approaches. We’ve been promised, actually, some funding for this and we’re looking forward to the time we’ll be able to do this more definitive clinical trial study, which needs to be done and, I should add, to date there have been no comparative clinical trial studies on any of the main approaches. The main approaches now being widely used are the behavioral ABA discrete trial approaches, the TEACH program, and the DIR/Floortime approach. We need studies that compare all three approaches in a clinical trial design so that we can tease out the questions that people want better scientific answers to, such as, “Is the emphasis of each approach, in theory, does that lead to the different kinds of changes each approach would predict one would have with the approach?” In other words, some of the approaches work on more surface behaviors; we work – using the DIR/Floortime Model – more on what we call the core deficits or core capacities that we feel also leads to symptomatic or surface behavior change. So, the studies that are being pursued are definitive studies that will compare the different approaches.


The next question is, “How expensive is the DIR/Floortime program?”

How expensive is a DIR®/Floortime program?

Will insurance pay for DIR®/Floortime services?

This is a good question because it's highly variable. The DIR/Floortime approach is basically a family-based approach. We have a number of schools that are using the approach and in our ideal world we would have schools working closely with families and both would work together so that the child's waking hours would be supported in terms of the types of interactions or learning interactions that are tailored to the child's nervous system and help that child learn to relate, communicate, and think all the time they're awake. The child would just be having fun and enjoying life and learning about the world and learning, eventually, his academic skills. But we would know we're doing this in a systematic, organized way, and schools and families would be working together, as well as therapists.

Now, if a family takes the lead and does most of the work, the program is relatively inexpensive. I have families come to see me, for example, who come to see me every four to six months for a visit, and are carrying out the program pretty well at home. Some of them live in areas where there are very few trained therapists around, so they're doing most of the work with me as their consultant. Sometimes they may have colleagues of mine here in terms of occupational therapy and a speech and language therapy working with them, too. But, that's relatively inexpensive – with periodic visits and the family carrying out the home curriculum, and we'll often talk with the school system and have reports for them and educators will work with us in the schools, as well, in some of these areas. So, that, I would say, is very, very inexpensive.



On the other hand, other families at the other end of the continuum maybe have helpers come in the house, either graduate students or trained therapists, for hours and hours a day working with the DIR/Floortime approach. Or they may be seeing one of my colleagues once to four times a week for organized Floortime sessions, as well as having three or four speech and language therapy sessions a week, and two to four occupational therapy sessions per week, and they might be in a private school that's also practicing the DIR/Floortime approach. As we know, private schools can be very, very expensive. So, there's a huge range from relatively minimal expense to enormous expenditures, depending on how a family organizes the program for themselves.

What's very interesting is that Rick Solomon in his community-based play project in Michigan, which is a community-based application of the DIR/Floortime Model, has shown that this program can be implemented on a community-wide basis using public funding through agencies with no cost at all to the families involved. That model could also be used where families would need to pay for their periodic consultations, but where someone visits the home on a periodic basis – once a month or even once every few months, or it could be as much as every couple weeks – and coaches the family, but it's also a family oriented approach and very much more on our less expensive side of the continuum.

So, the key thing about the DIR/Floortime program is that it's flexible in terms of the expense, depending on how a family wants to organize it. What's critical is that the interactions – what we call learning relationships – are tailored to the child's nervous system and that they're also tailored to the child's functional developmental level – where they are in terms of their attention, engagement, purposeful two-way emotional signaling, shared social problem solving, using ideas creatively, and using ideas logically. As we tailor interactions to the child's level of development and the child's differences in terms of how they respond to sights and sounds – whether they're over or under reactive, for example – as we do that, we have a DIR/Floortime approach. Again, these professional colleagues, such as speech pathologists and occupational therapists or people like myself or Serena Weider or others in our network of senior clinicians around the country, can be used as consultants or can be involved more intensively in terms of visits for the child.

So there's a wide range and what determines how the child does is not the expense, but really what's happening every day at home and in school – how well the program is orchestrated. Here I must tell you that some of the families I've followed who are doing the least expensive version have the best program organized because they're highly motivated and their schools may be highly motivated. Even the families that have not been having good cooperation with the local educational system have chosen to home school or just have their child in a partial day of school in order to have more time at

home – so maybe they have a half day of the school program for the social and peer interaction, and then the rest of the day at home for basic DIR/Floortime work and academic work related to it.

We do the academic work in a DIR/Floortime philosophy, where everything is taught so that it's thinking based. Some of the least expensive versions are getting the best results because of the way in which the interactions are occurring. So, there's no substitute for the human factor. Think about it this way: Spending a lot of money doesn't guarantee happiness, and spending a lot of money doesn't guarantee a good DIR/Floortime approach – it's that human factor, and it's being in the trenches, there, with our infants and young children and older children that counts.

“Will insurance pay for DIR/Floortime services?”

That's a frequently asked question and that varies from insurance policy to insurance policy. Again, the services often have to do with the services of different professionals – occupational therapists, speech pathologists, or it may have to do with a consultation with a child psychiatrist or a clinical psychologist – and different insurance will pay different percentages for different of these services, so that will vary from policy to policy. Again, some school systems now have this in their school systems and they'll provide the services. Some community agencies, like in Michigan, provide this now with public funds.

“How can parents find DIR/Floortime practitioners?”



How can parents find DIR®/Floortime practitioners?

What if there aren't any DIR/®Floortime practitioners in my neighborhood?

I would say check out our Floortime Foundation website (www.Floortime.org) and our ICDL website (www.icdl.com), where we have information about our senior faculty who teach others, and we now have our regional networks and senior faculty in almost every corner of the United States and many cities abroad. The best way of finding DIR/Floortime practitioners is through local networks and contacting individuals in the different areas and regions of the country. You can always call or email our Floortime Foundation, by checking our www.Floortime.org website or our www.icdl.com website and we can try to get more specific information for you.


“What if there aren’t any DIR/Floortime practitioners in my neighborhood?”



Recommended Resources

- Greenspan, S.I. & Wieder, S. (1998). The Child with Special Needs: Intellectual and Emotional Growth. Reading, MA: Addison Wesley Longman.
- Clinical Practice Guidelines: Redefining the Standards of Care for Infants, Children, and Families with Special Needs, The Interdisciplinary Council on Developmental and Learning Disorders, Bethesda, MD
- ICDL Training Videotapes on the DIR® Model and Floor Time Techniques, www.icdl.com

That’s a very important question and that’s frequently a challenge, and here’s where finding colleagues as close to your home in your area as possible when trying to have a consultation is very, very helpful. But also, again, when I say that the availability of professionals or the availability of financial resources should not be the factor that could change how well this program is carried out. We have a number of books and materials that are very straightforward, I hope, and, again, I welcome your calls to this radio show to clarify where it’s not, but there’s a book I’ve written with Serena Weider, Ph.D., called *The Child with Special Needs*. It’s written for parents and is available in



almost all the bookstores and certainly can be gotten from Amazon or any of the internet booksellers. It's called *The Child with Special Needs*, and it really outlines the DIR/Floortime approach with lots of examples. We also have on our websites, www.Floortime.org and www.icdl.com, from where you can download our Clinical Practice Guidelines, which also details the DIR/Floortime approach. We have training videotapes that can be purchased from www.icdl.com - 20 hours of videotapes, showing Serena Weider and me working with twelve different families that will illustrate how to get started and implement the DIR/Floortime approach. There are a number of articles that we've written that are available on our websites. Also, through the websites you can get in touch with regional networks and parents in different parts of the country, or hopefully in your area.


The key is to begin doing the kinds of interactions that help children engage and relate and learn to exchange emotional signals. Here, there's no substitute for getting down on the floor and starting to do it and exploring it until you find some colleagues to work with – to use the books and use the readings, to attend, perhaps, some of our national meetings, and network with other parents. But the key thing is a very activist approach, and even with the help of the best clinicians, it still boils down to getting down and trying different things and mastering the fundamental concepts.

So, there's a tendency to be very anxious, particularly right after a diagnosis is made, and to feel one has to be guided by a very well trained professional, and that's certainly always helpful. But, what I find clinically is that when parents and families can begin reading and jumping in there and trying ways to engage their child and get interactions cooking and following some of the guidelines we've established, in those families those children actually do the best. Then when professional consultation is available – even if it's a little later in the sequence – it can fine tune. But, by then you're already an experienced person who's tried different things, so, remember: Parents often do know best, they know their children best, and there are many ways to get information. Professional consultation is one, but reading and networking are other ways.

The next question is a really tough question: “If the DIR/Floortime approach is ‘so successful,’ why aren't there more clinicians, why don't children's hospitals recommend it, and why don't school systems use it?”



If DIR®/Floortime is so successful:

- **Why aren't there more clinicians?**
 - **Why don't children's hospitals recommend it?**
 - **Why don't school systems use it?**
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Well, one, why aren't there more clinicians? We'd love there to be more clinicians, but we've trained, probably at this time, over 40,000 clinicians in recent years. We have two annual conferences and have anywhere from 600 to 1,200 individuals attending each of the annual conferences, which are three and four-day conferences. We have an intensive summer institute certificate program for clinicians who want more advanced training and we have hundreds of clinicians who are in that program or who are in various stages of the program, and we have a senior group of faculty located around the country, who are present in almost every major city of the United States and regional networks. So, there are lots of clinicians who have been trained in this method – I would say somewhere in the thirty to forty thousand range – but not all are fully trained and not all through our summer intensive program, but it's growing rapidly. There should be more – we are trying to train more, but there are a fair number out there. Again, parents sometimes become the most skillful practitioners after they begin working with their children after doing some reading.

About children's hospitals – we have a number of children's hospitals that are now using the DIR/Floortime approach, such as Texas Children's Hospital in Houston, and a number of others. Many hospitals are recommending it now, along with other approaches, and letting parents make the decision about which approach to use. So, there are a large number of hospitals now that have this as part of their recommendation in terms of treatment options that parents should pursue.

For school systems the same thing is true. There are number of private schools popping up in all different areas of the country. The State of New Jersey just recommended DIR/Floortime as one of the approaches the whole statewide system is recommending. We have schools in the Chicago area and in New Jersey, in California, in Boston, and Atlanta, all using the DIR/Floortime approach, and we have a number of public school systems and private schools that are using it. Do we want it to grow?

Absolutely, and we're working hard with our educational colleagues and trying to create curricula and materials that make this easier to use in school systems. As you know, the more "cook-bookish" we can make an approach, the easier it is to use, but also we're dealing with the complexity of a human child with complex developmental problems, so if you make too cook-bookish, it isn't as helpful as when we have it flexible and when it can deal with the child's needs. So, we have to be balanced and be as specific as we can be to make it as easy as possible to master the concepts so the broadest possible range of children can have access to it because more and more colleagues will be able to use it. But at the same time, we have to honor the complexity of the child and honor the complexity of what we're trying to teach, and that balance is what's vital.

So, the answer to these tough questions is that we have a growing number of clinicians, a growing number of hospitals, and a growing number of school systems that are now employing the DIR/Floortime approach, and in most areas of the country now it's being offered together with other widely used approaches, such as behavioral approaches, and in many areas the TEACH program is an option.

The next question says that the materials that are cited are by myself or by my colleagues, Serena Weider, "Are there others using this treatment successfully?"



**Almost all of the materials in we have read cite
works by Drs. Stanley Greenspan and
Serena Weider.
Are there others who are using this treatment
successfully?**

As I mentioned, we have a wide range of senior clinicians now who are working with the DIR/Floortime approach and actually publishing articles and studies. A good

example is the study by Rick Solomon on his community-based DIR/Floortime approach called The Play Project in Michigan; Barbara Kalmanson in San Francisco; Barbara Dunbar in Atlanta; Molly Witten in Chicago – to name just a few – and many of you are familiar with in the New Jersey area with Monica Osgood, who started a school there. So, many colleagues are not only doing it, they're leading their regional groups, and are also publishing articles on this. You may want to see our ICDL newsletter and our Floortime Foundation publications, as well as the Journal of Developmental Learning Disorders to get a sense of the range of professionals who are now involved.

“The DIR/Floortime method demands a lot of time from parents. What about families in which both parents work – how can they use this approach?”



- The Floortime®/DIR method demands a lot of time from Parents. What about families in which both parents work? How can they use this treatment?

- Is the Floortime®/DIR method only successful for families that can afford to have one parent at home?

That's a very, very good question and the key answer is that grandparents can do this, nannies can work with this, graduate students can be brought in, even high school students can be brought in as helpers – but it is very important for parents to be very involved. So, where both parents must work full time, then you create as much of an extended family, bringing in friends, colleagues, hired helpers into the “extended family,” who become like family members for the child. It's really the quality of the interaction, the quality of the person, and having people who can hang in there for a number of years, not who are in and out of the child's life every few months that is critical. When possible, it's great for parents to be more involved because the child loves his parents most intimately and, obviously, from a point of view of emotional interactions there's

more meaning for the child when it's Mommy or Daddy. It's great when one parent only needs to work half time, for example, and have time to work with the child, or when one parent is at home. It's also great when both parents can work two-thirds or three-quarters time and share the work and the family responsibilities. I recommend that for all parents of young children where both parents want to work full time, I recommend what we call the four-thirds solution, where each one works two-thirds time so two-thirds are available for the direct care of the child.

Each family has to decide what pattern will work for them, and the key thing is having nurturing adults who can tailor learning interactions to the child's nervous system and developmental level, and that can be done in a variety of ways. So, it's not essential that one parent be at home or even be at home part-time, but it is very, very helpful when parents can share the work and parenting responsibilities. The main thing is that during the child's waking hours we have nurturing adults – and it can be a team of adults – who are interacting with the child in ways that are guided by the DIR/Floortime Model.


“Does the DIR/Floortime approach work with all children's developmental communication challenges, or just a subgroup? If so, what is different about this subgroup?”



Does the DIR®/Floortime approach work with all children with developmental and communications challenges or just a "sub-group"?

- If so, what is different about this subgroup?**

- Is it possible that the children in this "subgroup" were actually misdiagnosed and did not have ASD?**




We find that the DIR/Floortime approach works with all children with developmental communication challenges, not just a subgroup. In our study of 200 cases, we found that a subgroup of children – in our study it was the majority of children and, again, that was not a representative sample – but a subgroup made progress beyond our expectations and beyond what the field has come to expect, even in the most successful programs. These are children who went on to become highly creative thinkers, very logical, very abstract, very reflective, very empathetic, with warm peer relationships, they're in regular schools, and they're doing well academically. We've now followed these children into adolescence – some of them are off in college now – and the gains have held even without continuing intervention. The problems that the children do have are the problems that all teenagers have now, as opposed to severe developmental problems. Some of them have those kinds of challenges – negativism, arguments with family members, etc. and anxiety – and others don't. It actually is fairly representative of the population in general, we find. But that's the subgroup that's often referred to – the group that's done better than we expected.

The other groups of children – and we've divided all these children into four different groups – have also done better than expected, but not made these outstanding gains. So we have children who have a little more involvement in terms of neurologic challenges, but also were diagnosed on the autistic spectrum who've made consistent progress and are warm, engaged children using lots of language and enjoying some peer relationships, but don't have the level of abstract thinking or creative or reflective thinking that the group I just mentioned – the subgroup – has.

We have a third group that has even more involved neurologic challenges and they're making slower progress. But they're also warm and engaged and sweet – there is very little self-destructive behavior, like head-banging or self-injurious behavior – so, they're cooperative, they're sweet, they're engaged, they're loving, they're interactive and using limited language, but purposefully – short sentences, phrases – they're just not as high in terms of answering “why” questions. Whereas the first and second groups can answer “why” questions and be more involved in causal thinking, this group maybe will express their needs, but not yet be causal thinkers.

There's a fourth group that has more complicated medical, neurologic problems, often showing patterns of progression and regression, some have seizure disorders, some have subtle metabolic disorders that are being worked with, and even in this group we're helping them become warm, engaged, and happy and much more purposeful, but the language acquisition is more variable and the mastery of early academic skills is more variable.




So what we're finding is that for all the children with this approach there's greater warmth and greater relatedness and greater happiness on the child's part, and greater purposefulness in communication, in terms of gesturing, and usually some mastery, at least at some level, of symbols. Even for children who have oral-motor problems and had a hard time articulating, they were able to master some sort of a beginning symbol system, in terms of using visual symbols, pictures, the PECS system or computer boards. Some have surprised us – we didn't realize how much they were taking in until we got them more engaged and related and had been able to teach them to type, and now they're able to communicate with typing.

So, we're finding all the groups are making more progress than we would have expected, but the child's own neurologic profile determines in part how much progress he'll make, as well as our ability as clinicians and as parents to figure out the best ways to work with the child, and we're always trying to improve our ways. What's nice is that some children who we thought were in the third or fourth group made progress and then they're really showing the progress pattern of the second group. Some kids who we thought were in the second group showed the progress pattern of the first group. So, these groupings we're talking about are simply ways we're using for research purposes to try to understand some common characteristics. But each child is unique, and because the child starts off with more risk factors or more seeming neurologic problems it doesn't mean that they won't show a faster pattern of progress than we expected.

So we create an optimal program and let the child's progress determine how well the child does and, again, the DIR/Floortime approach is not an approach that's a "one size fits all" approach. It's an approach that says, "Let's do what's needed to help this child learn to master the fundamental milestones of relating, thinking, and communicating" and begin working on reversing the core deficits. We believe that's the right modern framework and philosophy for working with children with autistic spectrum disorders and other related developmental disorders; that approaches which have only one way of doing it aren't flexible enough to take into account the wide variation of seeing the way in which children with autism and other developmental disorders present. Everybody's nervous system is a little different, even if they share the same diagnosis, and we have to tailor it to their nervous system.

Another question is, "Is it possible that children in the subgroup that did so well – that became creative, abstract thinkers – were actually misdiagnosed and did not have autistic spectrum disorders?"

This is a very interesting question and I would answer it in an equally interesting way, which is that we're still as a field trying to figure out exactly what the nature of autism is. We use the term "autism" or "autistic spectrum disorders" to cover a wide




range of phenomena. Children share certain symptoms, such as a tendency to line up toys or perseverate, a tendency to repeat or script, rather than to use ideas creatively, and a tendency to be more self-absorbed. So, all the children we've worked with in our 200 case study and many of the children we've worked with clinically all meet the criteria developed by the Diagnostic System developed by the American Psychiatric Association for autistic spectrum disorder. If you use a formalized rating scale, such as the Carr Scale or one of the more research oriented rating scales, such as the Autism Diagnostic Interview, they all will pass the line that suggests they are in the autistic spectrum.

But, to my way of thinking this doesn't mean a great deal because having these symptoms is a little bit like having a fever or having an inflammatory reaction. There are many different pathways to a fever – you can have it because of an infection, you can have it because of a metabolic disorder, you can have it because you're overheated, etc. So, there are many different reasons why you might have a fever or an inflammatory response. You can have an inflammatory response based on an allergy or based on an infection. Similarly, there may be many reasons why you have some of the symptoms that occur and lead us to diagnose autism.

I prefer to think of the primary symptoms and secondary symptoms, primary being deficits in relating, thinking, and communicating and secondary being self-stimulation, repetitive behaviors, a narrow range of interests, etc. My own view is that children are different neurologically and with further research we will find that certain children – as we're finding already in our clinical studies – make very rapid progress once we work with them – and I would say – in the right way – underline the word “right,” which means working off their affect or off their own emotional interests to help get them cooking. So, I follow children now whom I thought had great prognoses and some have used the model that we're advocating where we work off their emotions and help them learn to become creative thinkers. Others I've followed, but their parents have elected to use more structured approaches, where they're taught based on rote memory skills, either using ABA discrete trial or some similar approach, but the parents may come in periodically just for additional advice from me, and I've learned a great deal by following these children. I've found that the course of progress is very different and that you get what you practice. If you don't work on relating and spontaneous use of emotional gesturing and creative use of ideas, the children stay more rigid and stay more perseverative, even those I thought had great prognoses from the beginning.

So, the answer to the question, “Do some children not deserve the diagnosis of autism but are diagnosed that way, maybe mistakenly so” suggests that autism is a unitary entity that's well understood and is a simple syndrome like a strep throat, that either you have or you don't. What I'm saying is that children evidence a range of individual



differences in the way they process information – in the way they respond to the world – having to do with their different biology. But this is subtly different for every child, and my hunch is that you’ll find different genetic patterns and different pathways for each of these different patterns we’re seeing in different children, even though they may share a few things in common, like a tendency when overwhelmed to be self-stimulating or perseverative.

So, we’ll find many, many different subgroups. We’ve divided the world into these four subgroups temporarily for research purposes. My hope is eventually that what we call “autism” now will be many, many different subgroups of central nervous system differences and we’ll have specific intervention patterns for each one of these, as we’re already developing. So, we do very different things now, for example, with children who are sensory hyper reactive versus children who are under reactive or children who are sensory craving. We work differently with a child who’s already a shared social problem solver and a child who’s just learning to engage.

So, that’s where I think the future is and the future isn’t so much “is a child autistic or not autistic” or is he in that gray zone right between where he shares some of the characteristics and doesn’t share some of the characteristics. I don’t think it’s necessarily all that useful to try to categorize in that way, because we have challenges that exist on a dimension or on a continuum from more or less. The key thing is harnessing the learning environment to bring out the best in each child. I’m only too happy to say that a child doesn’t deserve the diagnosis of autism anymore and perhaps never did deserve the diagnosis of autism, even though they may have shared some of the symptoms or characteristics.

What I like to do when I meet with parents is to ask them to tell me where their child is on a 1-10 scale in terms of his ability to relate and engage warmly, in terms of reading and responding to emotional signals, and in terms of using emerging ideas creatively, rather than in a scripted or rote way. Based on that, we see where the child is, and then we see what kind of progress the child is going to make. So, there’s always been a tendency to try to use a categorical thing and if children do well to say they were never autistic to begin with, and certainly children who have more severe neurologic impairments have a harder time making rapid progress. But the idea is that you help all children reach their maximum potential and see autism, or what we call autism, as really a multi-faceted disorder with many different pathways and with symptoms that exist on a continuum that should be thought of as more dimensionally, rather than with narrow categories.


“Are there children for whom the DIR/Floortime method does not work at all?”

Are there children for whom the DIR®/Floortime method does not work at all?

- How do parents know if their child is likely to benefit or not?

This is also a very good question, and a direct and difficult question. We've found children who make slower progress and children who make more rapid progress. Because the DIR/Floortime is an analytic model, a framework for understanding how the child's nervous system works and where the child's strengths and weaknesses are and how to tailor learning interactions for your child, we're always trying to find a better way of working with that child. So, in that sense I would say there is no child for which the framework can't be applied as a way of helping understand that child and trying to organize the best approach for that child. You have to remember that the DIR/Floortime Model incorporates biomedical approaches, so for some of the children, for example, who have abnormal EEG patterns – that is, their brainwaves in certain parts of the central nervous system are not showing the expected normative pattern – they may be put on a medication such as Depacote, an anti-seizure medication by their pediatric neurologist or by their developmental pediatrician. That would be part of our approach – we'll be working with parents on engaging the child while the medication is being used, and later also, if medication is no longer necessary at some point.

Children who have metabolic problems – that's also part of our model, to incorporate the treatments for metabolic problems into the overall thinking of the framework. Children who have severe oral-motor problems, so they have a hard time making sounds and using emotional gesturing that involves sounds, will have intensive oral-motor work with a qualified speech pathologist. Some of the children we find need more structure and more repetition to master basic skills, like imitation, which is a pivotal point for learning other skills. We'll involve more structured approaches in their work. We've included for some of the children – and it's just a small component of their




program – behavioral approaches, as well. We have a curriculum called the Affect Based Language Curriculum (ABLC) that we use that has both very structured elements in it, as well as very spontaneous Floortime elements in it.

So, to summarize the answer to that question, the DIR/Floortime approach is very flexible. It can have structured elements, including even behavioral elements. We have a language curriculum called the Affect Based Language Curriculum that has very structured elements, as well as dynamic applied Floortime elements in it. We emphasize whatever is needed to help that child move up the developmental ladder. So, the DIR/Floortime Model incorporates structured, as well as spontaneous elements. It incorporates biomedical elements and it incorporates very focal work, like oral-motor work, to help children who have trouble making sounds or even some children who have difficulty eating. So, it's a model – it's a way of understanding the child's nervous system, understanding how the child's mind is developing. If you think about what DIR means, it means understanding where the child is developmentally (“D”) in terms of emotional, social, and intellectual development; “I,” meaning how his biological or her biological differences are expressing themselves, that is how they take in sounds and sights and smells and touch, how they organize responses to the world; and “R” – how do we orchestrate learning relationships – how much structure, how much spontaneity, how much each day, by whom and how – learning relationships that are tailored to that child's nervous system and developmental level.

So, in a sense, it's not a question of whether the DIR/Floortime method works for all children. It's a question of using it as a model, a framework, to help all children make progress. We feel that it is the most comprehensive model currently available for thinking through problems that children have, especially complex developmental issues faced by children with autistic spectrum disorders and other similar developmental problems.

So, this last question – which is probably the best question – comes really to the core of what the DIR/Floortime Model is about. It's a way of figuring out how to be helpful to each and every child, and a way to keep working with the child, and the most important thing – and I'll emphasize this over and over again in future shows, but this is what's important to keep in mind, particularly for those families and parents where children are not making the progress we would like – which is no matter what's being tried new and innovative – and there are many new and innovative things out there, from nutritional to biomedical to new kinds of curricula or new kinds of “interventions” – we have to have a framework, a way of organizing these in a meaningful way, and the framework must emphasize the basics. That is, you always keep the child engaged, related, trusting, and as happy as he can be. Always help that child read and respond to




your emotional and social signals, so the child becomes purposeful and communicative at some level. And always keep working up the hierarchy – up the developmental ladder to higher levels of social, emotional, and intellectual development.

We need to remember these basics so when we're trying new things to work with the child's challenges, whether it's a seizure disorder or whether it's a metabolic challenge, while keeping the basics cooking. The problem I see is when a child has many challenges and is not making progress, we tend to look for this or that approach, or this or that new intervention, which is fine to do as long as you integrate it within the basics. It's a little bit like trying in one's own diet, if one is trying to feel better: You've got to do the basics of exercise and have the basic balance of protein and carbohydrates, etc., and then off that you can build innovation and try new things. It's the same thing here: We have a foundation for all human development, especially children with special needs, having to do with forming relationships, becoming involved in intentional two-way communication, and learning to problem solve together, and in having families that always keep that basic relationship cooking. Off that, we then can try new and innovative therapies or interventions that meet the particular challenges of that child.

So, that's the important thing. The harder it is for a child to make progress, the more we have to keep the basics going while we're thinking of new solutions for some of the child's challenges, which are not always easy to find. But, don't give up the basics while we're on the search. Those are the families that do the best long-term, I find, and when they do find something that's helpful for that child – to help that child be calm or to help remedy the metabolic or neurologic problem – if they kept the basics going there's a warm, loving child who's feeling secure and ready to then use the new interventions and new innovations or new discoveries. So, always keep the basics going. That's really the heart of the DIR/Floortime model.

So, that takes us to the end of our questions. This series and today's session I would again like to emphasize is not just frequently asked questions, but should be relabeled the toughest questions we could come up with and that you could come up with. And we hope we've answered them and that they've proved useful.

Next week we're going to focus our show on a review of all the different innovative interventions that are out there – or many of them, at least – from diet and nutritional interventions to technologies that are there. The theme of next week's show will be how to keep the basics going while pursuing different emerging strategies. So, we'll look at all the strategies that are sometimes considered alternative, as well as strategies that are not really alternative, that have a lot of research behind them but are not yet part of most programs. And we'll separate out programs that are geared to



strengthen particular parts of the nervous system, like motor planning and sequencing, but may not have been tried on “autism,” per se, as a syndrome, but are helpful for components of what children with autistic spectrum disorders have challenges in doing. So, we’ll clarify all that and we’ll call next week’s show, “Exploring the Intervention Horizons While Keeping the Basics Cooking.” I look forward to speaking with you next week. Bye-bye.