

ARTICLE

Expanding our Toolkit through Collaboration: DIR/Floortime and Dissociation-Informed Trauma Therapy for Children

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This article describes the first author's supervision of the practice of a therapist originally trained to work with developmentally delayed children using the DIR/Floortime Model. The Floortime therapist discovered that her practice contained children demonstrating dissociation and posttraumatic play and received supervision and certification in trauma therapy. The combination of Floortime techniques with awareness of trauma treatment principles led to rapid progress and developmental leaps with her clients. The authors describe how each of their practices were enriched by the collaboration. A case study describes how changing to a trauma-sensitive and dissociation sensitive perspective promoted the growth of a child with many autistic features.

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INTRODUCTION

In my role as supervisor for many clinicians working with dissociative children around the world (JS), I made a remarkable find—a therapy technique

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that focuses on affect regulation and attachment as the foundation for integrated emotional and social development. What could be more appropriate for traumatized children? Interestingly, this model called DIR/Floortime (Stanley Greenspan and Serena Weider, 1998), was designed for developmental delays and emotional challenges, specifically, those inherent within the autistic spectrum population.

My unexpected discovery began with a request by two Floortime specialists whose professional degrees were in speech and language pathology to enroll in the international online course I developed with Frances Waters on child dissociation and trauma. Impressed with their advanced knowledge on the subject, Frances Waters and I accepted their request.

Surprisingly, these clinicians presented extremely dissociative, severely traumatized children who had been referred initially due to delays in language and impaired attachment. Many of the children who had begun therapy with these practitioners appeared to be autistic; avoidance of eye contact, twirling, repetitive movements, language delay, rejection of affection from mother and father, overstimulated and reactive by seemingly minor stimuli. However, as the children responded to the therapists' nuanced, careful, attachment-based approach to treatment—a very different understanding of their symptoms began to surface.

These children displayed discrepancies that were very atypical for developmentally delayed children. For example, they displayed high-level conceptual skills while presenting at other times as having limited cognitive abilities. Some of the children, who had displayed secure attachment at earlier ages, began to exhibit avoidance of their parents and chaotic behavior.

Gradually, using the tools of DIR and the Floortime method, the children began to play out troubling scenarios that had the markings of post-traumatic play. Children in their play were taken in buses and vans and abused by “robbers.” Rescue was impossible, and the same scenarios were repeated over and over again. Even when the therapists introduced rescue, the helpers, too, would turn out to be bad people.

Sometimes the play provoked intense dissociative reactions (Silberg, 2013; Waters, 2016). Some of these reactions looked like dazed, frozen nonresponsive states, or total collapse sometimes called “dissociative shutdown” (Silberg, 2013). At other times, the children giggled uncontrollably, or repeated rhyming syllables and seemed to put themselves in trances. These therapists were trained through Floortime to notice children's shifts in affect and to help regulate the children with soothing props such as hammocks, ball pools, giant beanbags, and other sensorimotor interventions. By the time these therapists had enrolled in the ISST-D course, they recognized that they had severely traumatized children on their caseloads. Furthermore, they recognized that the children's shifts in state were signs of trauma-induced pathological dissociation.

Some of these families, suspecting that their children's symptoms might have a traumatic component, had sought trauma therapy for their children. However, some were dissatisfied with the treatment offered by the trauma clinicians and did not want to return. The parents reported that some therapists tried to engage the children in verbal discussion initially, which resulted in further avoidance and little disclosure. According to the families, some therapists concluded that if the children did not verbally report what had happened, it was not possible or important to address it. The Floortime therapists, on the other hand, showed patience to stay with the child's comfort level, to tune in to their play even when they were nonverbal, and had initial goals to increase the children's comfort and attachment and not to seek out or address trauma.

As a result of reaching out to each other for joint supervision, the two Floortime therapists discovered that their young clients were playing out similar kinds of abuse scenarios, and soon they suspected that the same perpetrators who apparently had access to the children via the transportation system of a local school were abusing their clients.¹

The huge irony in this strange tale is that many community trauma-informed psychotherapists, at first, could not see the same evidence of trauma that these Floortime therapists saw. Intervening on a cognitive level with the children did not access the dissociated content of torment and trauma. Many of the children with severely compartmentalized dissociative states could function normally at school despite having troubling episodes of sexual acting out, or sleep disruption. Some of the community trauma therapists did not have a model to approach severely delayed and unresponsive children. Some therapists missed the state changes that signified dissociative shifts, felt unqualified to work with children with developmental delays, or misunderstood dissociative states as a conscious resistance to therapy.

On the other hand, the DIR/Floortime therapists promoted regulation, attunement with the therapist and parent, and followed the child's lead by joining his play. When mismatches between affects and behaviors, and strange anomalies in developmental level emerged, the Floortime therapists understood they were seeing something different than they had experienced before. They sought consultation and supervision from trauma therapists and were encouraged to keep the cases under supervision because the children had developed a feeling of safety and trust in the therapeutic environment of the Floortime therapists.

Some therapists in the community at first rejected the findings of the Floortime therapists. Several years later, however, when verbal, older children were seen by some community therapists and described the same content these young children had played out in the Floortime offices, some other therapists concluded that they too were seeing children with similar traumatic histories. Help for many of the families and involvement of law

enforcement were significantly delayed, because the children's fragmented recollections during the Floortime therapy shown initially in play were difficult to piece together, there was significant denial regarding the safety of schools, and it was difficult for the Floortime therapists based on the symptomatic presentation of the children, to convince authorities to investigate the possible criminal activity or to influence schools to improve safety.

When I was consulted, I entered an environment of intense controversy. On one side were the Floortime therapists and a well-known local trauma and dissociation specialist who served as their direct supervisor. All three were convinced that there was a horrible abuse scandal in the community that was not being addressed. On the other side, were well-trained child therapists who were not finding the typical signs of trauma in many of the children they saw, and were suspicious of possible suggestive techniques used by the Floortime therapists. This concern was partly fueled by cases sent to them of children who had no symptoms or disclosures at all, but anxious parents who were fearful of the abuse stories circulating in the community. Fortunately, Floortime practitioners videotape their sessions, and so I was provided with years of therapy on videotape of multiple children in order to develop a hypothesis about what was happening in the community.

After interviewing many of the families and children myself and watching the videotapes of therapy, I was convinced that the Floortime therapists had uncovered a community tragedy. I had been engaged to teach the community and clinicians about dissociation and trauma in children, yet I discovered I had a lot to learn about treating traumatized children who present as developmentally delayed. For me, the Floortime techniques were like a golden key that helped unlock the psyche of young traumatized children.

WHAT IS DIR?

DIR is a developmental model of assessment and intervention for emotional growth developed by Dr. Stanley Greenspan, child psychiatrist and Dr. Serena Weider, clinical psychologist (Greenspan & Weider, 2007). The DIR model is the theoretical basis for a set of interventions that enhance the social-emotional development of children with a variety of deficits. The primary goal of these interventions is to enable children to form a sense of themselves as intentional, interactive individuals and to develop skills across multiple domains.

DIR is a "transdisciplinary" approach in which practitioners from a wide range of disciplines learn from each other, incorporating one another's perspectives, and use this broad knowledge while treating the child. This

approach to sharing knowledge is particularly appropriate for young children because of the multiple disciplines and domains that are affected by development.

The DIR assessment procedure carefully parses how deficits in developmental functioning can affect primary relationships and emotional growth and, in turn, how impaired relationships can disrupt development. The DIR innovators have developed a detailed assessment tool, the FEAS *Functional Emotional Assessment Scale* (Greenspan, DeGangi, Weider, 2001). In addition to videotaped assessment, the DIR therapist gathers interdisciplinary information about the child's functioning in all arenas. The FEAS is a reliable, age-normed, clinical rating scale that can be applied to videotaped interactions between children and their caregivers. The FEAS provides information about the child's delayed emotional and social development based on the individual profile of the children's developmental achievements across multiple domains.

DEVELOPMENTAL, INDIVIDUAL DIFFERENCES AND RELATIONSHIPS (DIR)

The letters, D, I, and R, stand for the three components of this model that are assessed and addressed.

D: Developmental

Greenspan and Weider (1979) have organized a developmental scale of emotional levels from infancy through the development of mature self-reflective abilities. The first six levels are: self-regulation, intimacy, reciprocity, building a sense of self, emotional ideas and emotional thinking.

Within each emotional level are capacities such as the ability to: initiate interaction; sustain engaged intimate interactions surrounding emotional experiences and themes; respond to and use complex gestures, (including facial expression, gestures and intonation); understand theory of mind; express empathy; and show the ability to problem solve.

By analyzing these emotional levels into basic components, the therapist is provided with a fine-tuned analysis of what the child lacks emotionally, where growth is needed, and where developmental irregularities occur. So, for example, if a child can at times accurately name their own affective experiences, but also shows a mismatch between affect and content at other times, that irregularity becomes obvious to a therapist familiar with the details of this hierarchy of emotional levels.

A 10 year-old girl observed by the author (JS) in a Floortime office froze into a dissociative state and then regressed to a child-like state during a discussion of anger. Later, she accurately identified her feelings in a sophisticated way as "hopelessness." This high-level emotional analysis coupled

with developmental irregularities was apparent to the Floortime therapist because of her finetuned familiarity with the sequential levels of emotional development. The kind of sensitivity that this knowledge promotes allows small moments of emotional avoidance to be accurately noted.

The DIR therapist notices when the child plays with a “gleam in the eye” or if there’s a broad range of differentiated emotions. This leads to keen clinical analysis. For example, the DIR therapists suspected that children twirling their hands and staring during stressful moments in play were reacting emotionally with dissociative avoidance, rather than reacting to sensory overload as autistic children often do.

In addition to a comprehensive knowledge of emotional development, the DIR therapist is required to have a finely tuned understanding of the development of play.

Greenspan and Wieder have organized play within these emotional levels, beginning with representational play and moving through the continuum to higher levels that involve creating symbolic scenarios with a clear beginning, middle, and end. Most play psychotherapists are accustomed to the most advanced level in their offices. For example, the play of a normally developing 5-year-old child will include an ability to take the perspective of the character he chooses to be; he will include themes that are beyond his daily routines and his play will be diverse, in that the same characters and objects will be used in many different ways.

I: Individual Differences

DIR therapists look at sensory regulation, motor skills, language, communication, visual spatial perceptual processing, neurological abnormalities, auditory processing and cognition within each individual child assessed. Because every child’s profile is different, interventions must be based on the strengths and deficits each child shows in each of these areas.

The DIR therapist learns how each of these components interact with each other for a sophisticated analysis of the factors affecting the child’s developmental growth and determination of the reasons for delay in any of these areas. The DMIC (The Diagnostic Manual for Infants and Children, ICDL-DMIC, 2005) describes these patterns in detail.

For example, children who have had overreactive sensory systems might react to attempts at enthusiastic engagement of a caregiver or therapist with survival mode avoidance. Some parents (and therapists) erroneously respond to an underresponsive child who is in sensory overload with loud or forceful talking, but this can, in fact, dysregulate the child more, causing more avoidance and shutdown.

R: Relationships

The DIR therapist assesses the quality of the caregivers' mutual relationships with the child. The therapist assesses caregiver patterns such as sensitive responsiveness, attunement, and mutually confirming interactions. These types of interactions include mirroring behaviors, matching gestures, and expanding behaviors. The DIR therapist also assesses the security of the attachment and the parents' ability to initiate soothing interventions. The DIR therapist also looks to see the comfort of both parents and child to express a full range of emotion.

Floortime

The intervention stemming from the DIR approach is Floortime, a parent/child-focused therapeutic approach. The Floortime model teaches caregivers to follow the child's natural emotional interests and create states of heightened pleasure in playful interactions tailored to the child's unique motor, sensory, and cognitive processing profile. The goal of these interactions is to promote growth through strengthening the connections between sensation, affect and motor action (Greenspan & Wieder, 1998).

Parents are trained to encourage secure attachment in their child by a therapist who is cued in to all of the developmental, individual, and interactional disruptions in the child's growth. For example, the therapist might note that challenges in secure attachment are due to a mismatch of a parent's and their child's sensory profiles or a lack of awareness of difficulties in sensory processing.

Floortime is the place where parents learn to match their child's rhythms, read their cues, and experience joyful interactions that are warm and engaging. Sensory games and toys that stimulate imagination are used not for the goal of teaching the child how to play, but rather as a means to enter the child's world. Parents are trained during real time, on the floor, playing and interacting while taking into consideration the child's individual sensory-processing profile and their child's developmental levels. Floortime creates the ultimate opportunity for the child to integrate the emotional experience of engaging fully with his parents in a coregulated "flow."

Floortime encourages change in what is called "just the right challenge." The change is usually introduced within a familiar activity the child has mastered and enjoys. In many cases, children with motor planning difficulties, processing challenges, or anxiety will engage in repetitive play that is predictable and may provide a sense of mastery. DIR therapists "up the challenge" by making a small change, either in one area of development at a time or by supporting the integration of different developmental areas. During "Talktime" these same goals are pursued through verbal discussion.

The DIR model is a highly optimistic model for the treatment of children who show developmental deficits. The theory predicts that at any stage in a person's life, repair can be done by caregivers, teachers, and/or therapists who can learn to become attuned to the child's emotional development, their individual differences, and the quality of their relationships. This sensitivity to these three areas promotes therapeutic skills that can teach the caregiver to become increasingly more attuned to the child, focus on enjoyment in interaction, match the child's emotional states, and help the child develop emotionally within the context of safe attachment. Autistic children benefitted greatly from this model, which often changed the way professionals perceived the potential of some autistic children (Greenspan & Wieder, 2007).

As Greenspan (1993) explains: "The idea behind Floortime is to build up a warm, trusting relationship in which shared attention, interaction, and communication is occurring on your child's terms. . . . When that warm trusting relationship has begun to blossom, you are laying the groundwork for tackling any and all challenges that your child faces," (p. 26).

CONSISTENCY WITH CURRENT NEUROBIOLOGICAL THEORIES OF TRAUMA'S IMPACT ON DEVELOPMENT

The trauma-attuned reader will realize how closely the theories of DIR/Floortime match current thinking about how healthy development in a safe environment promotes brain growth, and how the disruptions caused by trauma impair the development of basic functions. DIR/Floortime methodically addresses key components of brain function known to be disrupted by trauma. These key components are the attachment system and the affect regulation system, which when functioning properly allow for cohesion in identity, awareness, and the ability to regulate despite incoming threatening stimuli.

DIR/Floortime therapy directly targets the attachment system promoting changes in the parent-child relationship, teaching attunement, and state matching, which allow the child to feel connected and supported. DIR/Floortime directly targets affect development by noticing subtle aspects of affect change and matching them, commenting on them and having the parent share these moments. The therapist always aims to keep the children within their "windows of tolerance", with multiple sensory stimuli—ball pools and hammocks that soothe and contain the child when they are aroused.

As we now understand from the work of Schore (2009), LeDoux (1996), Siegel (2003) and others, these specific activities promote brain growth. Schore (2009) explains that secure attachment promotes maturation of the right orbitofrontal cortex. This area of the brain allows an individual to modulate extreme levels of emotional arousal.

Many neurobiological theorists stress the central role of “affect” as an organizer of brain development. Affect is viewed as the central integrating process that organizes perception, thought, and motor activity – and this integrative activity is viewed as the central core of the role of “affect.” (Siegel, 2003) Other theorists also emphasize affect as the binding force, or the “psychic glue” (Silberg, 2013), in the construction of cohesive identity (Tomkins, 1962; Schore, 2009). Schore explains how affect development in the context of a loving relationship creates the neural connections that strengthen the brain’s capacity to regulate.

The development of affect rapidly promotes healing, because “emotion is both regulated and is regulatory.” (Siegel, 2003 p.30) That is, emotional flexibility helps serve to regulate other mental processes as well. The right hemisphere, which is stimulated during attachment experience, is specialized for “generating self-awareness and self-recognition” (Schore, 2009, p. 127). Current trauma therapy for children and adolescents strongly supports affect regulation as a key component in all newly developing approaches for complex trauma (Ford & Cloitre, 2009.)

Trauma leads to the disruption of the brain’s ability to process perceptual information, which in turn impairs self-awareness and the ability to regulate in the face of traumatic reminders (van der Kolk, 2014). The DIR/Floortime therapists, in their ongoing efforts to keep the child feeling safe and regulated, further help to build ongoing self-awareness. As stated succinctly by Siegel (2003),

“...communication within attachment relationships is the primary experience that regulates and organizes the development of those circuits in the brain that mediate self-regulation and social relatedness. . . Sharing emotional states is a direct route by which one mind becomes connected to another. . . The attunement of right-to-right hemisphere may be crucial in establishing the secure attachment environment which may be essential for effective therapy to occur,” (p. 31).

When DIR/Floortime is viewed within the context of developing neuropsychological research, its profound effect on young traumatized children becomes clear.

In the Floortime work with traumatized children, I, (CL, second author) have been able to accomplish the crucial work on attachment by actually rebuilding trust with parents through attunement. These children have suffered betrayal at the hands of abusers, a betrayal that words will not easily soothe. It is only in the intimate moments of right hemisphere connection, as they look into Mommy’s eyes and see the love, feel the gentleness, and hear her words of truth, that the beginnings of repair take hold. In Floortime, the therapists try to create as many moments and opportunities as they possibly can to build these connections. These connections then

provide the baseline for further advances on the attachment continuum so that children learn empathy and reciprocity in relationships.

I observed the dysregulation these children presented in the beginning of the process just from hearing the words “I love you,” and how the children begin to tolerate the intimacy, and then enjoy it, and then even ask for it, and how they ultimately use the relationship to ground themselves in situations where they are overwhelmed by emotion. The fear of being hurt is intrinsic in their process, yet with consistent messages of safety in the relationship, the children relearn to trust the parent and to form trusting and intimate relationships with the therapist and other attuned caregivers. In fact, many of them, as they continued to heal, actually articulated why they were confused about what love really means, why they did not trust the parent or therapist, and how they can now know the difference between a safe relationship and one that is hurtful or dangerous.

The Floortime model accesses the neuropsychological roots of dysregulation by focusing on the attachment relationship, slowly building awareness, and promoting affective development in small baby steps at the most primitive neuropsychological level. A “talk therapy” that presumes these developmental milestones have already been achieved may have minimal effectiveness for children who require reparative work on the most primitive areas of brain function through the development of the attachment system to promote affect development and awareness.

THE INFLUENCE OF DIR/FLOORTIME ON JOYANNA SILBERG’S THERAPEUTIC WORK

My practice (first author, JS) has been profoundly influenced by my contact with the Floortime specialists who were treating traumatized children. As Frank Putnam (2016) states in his new book *The Way We Are*: “States serve as the language of attunement and attachment. More powerful than words, this first dialogue of state. . . crystallizes in the form of an attachment status that echoes across the individual’s life” (p. 49).’ The DIR/Floortime model recognizes the importance of the “states” children present by looking at the whole child—his affect, quality of movement and language, relatedness, and regulation—and adapts a therapy approach that helps the early regulation of these states in the context of attachment.

I have learned to more carefully watch activation of the whole body and to more closely observe affect and body carriage as well as developmental level, verbal skills and level of play—thus tuning in more quickly to the child’s pleasure or discomfort, and my interventions being accepted.

My ability to create safety in the therapy room has been enhanced through attention to sensorimotor activities and stimulation that can have regulatory effects—drumming, marching, rocking. I have become more sensitive to regulating the child quickly when a child shows dissociation and

loss of control. I also find that I am more regulated myself during a child's collapse into dissociative shutdowns, because I have become aware of many more of the sensory and affective triggers that can create these reactions.

I have always liberally included parents in the therapy room in my practice, but now I utilize their presence more directly as co-therapists and helpers, always looking for new opportunities to build attachment and attunement.

Certain discontinuities in development now have more meaning to me, such as inability to engage in symbolic play, which I now understand as not only cognitive but an emotional block. My awareness of the levels of play and communication skills is enhanced, although a full training in DIR will further heighten this sensitivity.

Although I often use a directive play therapy approach wherein I bring up issues I want addressed (Silberg, 2013), I now take greater interest in changes of direction initiated by the child. I also believe that my own capacity for attunement has improved as I have developed more appreciation for the subtle nuances of voice, posture, breath, and quality of movement that can match the child in whatever state they may present. My time on the "floor" of my office is more precious to me, as I appreciate how early developmental play may hold important cues to the child's emotional blocks.

THE INFLUENCE OF DISSOCIATION-INFORMED TRAUMA TREATMENT ON CHEVY LAPIN'S DIR/FLOORTIME PRACTICE

It is sometimes hard to imagine how life was and how my use of Floortime was before I (CL second author) began treating traumatized children. It was a road that I did not initially choose to travel, but I feel grateful for and honored by the trust that these children had in me. Once I found myself on this road, there was no turning back. The first tools I added to my toolbox were a lesson I learned from Joyanna Silberg: To believe in the integral goodness and purity of each child, regardless of what had been done to them, and to believe in their desire and ability to heal.

Practically speaking, the principles of trauma therapy, as well as the understanding of the unique ways in which trauma and dissociation affect children, have impacted the way that I now work in many ways.

I feel that I have an even deeper and richer understanding of the magnitude of the therapeutic relationship and, even more so, of the value of building and rebuilding secure attachments with the child's primary caregivers.

My therapy room has changed in some aspects as well. Floortime rooms are meant to have a large variety of all types of toys that stimulate imaginative play. These toys include costumes and props, assorted figurines, puppets and play buildings for all ages, dollhouses and furniture,

toy vehicles, and sensory equipment. The changes I have made in my clinic include a sand box, a corner for preparing aromatic teas, hot chocolate milk with straws and cups of different shapes and sizes, a large variety of soft and cozy stuffed animals that soothe, emoji pillows, and a “feelingmometer” to measure how giant feelings can get smaller. I now have many boxes: boxes for secrets and boxes for happy feelings and boxes for dangerous characters and scary nightmare pictures.

A new addition is a small table and chairs as well as a small couch, suggested by Dr. Silberg for art work and other activities we engage in at a higher cognitive level as we move “up from the floor.” These additions have shown remarkable results. Children know that sometimes we will play and other times we will talk. This is a place where we can sit together drinking warm or cold drinks and process the many overwhelming emotions and behaviors that a traumatized child may deal with in and out of the therapy room.

The use of Floortime strategies created the setting that allowed the children to disclose their abuse. I have learned, through my supervision and my studies in psychotherapy, how to *respond* to these disclosures in a way that keeps the child aware that he is presently in a safe place, thus making it less likely that the child will fall into the trauma “vortex,” the cycle of triggers and reenactments that keeps the child frozen in time in the traumatic past. Some of these tools include: Slowing things down and trying to do them again together, the use of mindful breathing, and somatic activities that allow tuning in to body signals of distress.

I learned to improve my use of the basic Floortime strategies to adapt to the needs of the traumatized child. One of the most central strategies to Floortime is to “follow the child’s lead.” Following his lead includes being in tune to his emotional state at any given moment, noticing, and responding to it. For traumatized children this might mean not addressing traumatic content until the child indicates readiness through their ability to find safety in the playroom.

Following their lead helps a child recognize that it is their intention and ideas that lead what will occur during the time together. I have seen how children who were previously perceived as lacking initiative and imagination began to show their strengths in these areas. Watching a traumatized child connect with their own power and initiative is compelling to witness. As stated to me by a five-year-old traumatized girl, “I only like talking about the scary things here, you know why? Because here I AM IN CHARGE!” She continued explaining that here she decides if she will agree to discuss difficult topics and that she can also choose to stop when it gets too much for her.

Another Floortime strategy is to connect affect to meaning by verbalizing what the child might feel. For example, if a child wanted to play eating candies and he said this without affect, in the past I may have been tempted

to jump in and excitedly say “Yippee! Candies!” However, I learned that there are children who have been tricked, betrayed, and hurt by people using candies, and that their lack of affect is a clue to their emotional state. What I have learned to do is to watch and wait (and self-regulate), to wonder aloud about the feelings about candy, and not to assume the “right affect” too quickly.

The DIR model uses play both as an assessment tool and as a tool to help the child reach higher emotional developmental levels. Although the DIR model invites us to be attentive to every aspect of development, there are pitfalls in assuming that what we observe through the DIR “glasses” is the whole story. I learned to expand my analysis of play to include the possibility of trauma as a possible cause of derailed development.

The trained DIR therapist is trained to understand repetitive play as a possible motor planning deficit. Although this is true for many children, we must also be trained to look out for posttraumatic play. Posttraumatic play may look fragmented and rigidly repetitive, lacking sequence and appropriate affect or resolution (Silberg, 2013). The child may repetitively use “approach and avoidance” before he feels safe enough to play out his story. If the child has difficulty creating a logical sequence in play, he may be playing out the trauma as he recalls it, in a fragmented nonsequential way. The child may begin to play something out that triggers strange behavior such as: a strange sound; jerky or quick movements; sudden collapse; frozen body; hyperactivity; throwing toy pieces all over the room; or appearing to be in a trance. These reactions may be forms of dissociation as seen in traumatized children (Silberg, 2013), a primitive method of emotional avoidance.

One of the basic play milestones according to the Floortime model is to encourage the development of symbolic thinking. In DIR terms, symbolic play is the stage at which a child can take on the role of another character and play out the motivations of that character. The traumatized children I treat who reach this important milestone now play out scenarios of abuse and use their symbolic skills to play out rescue scenarios, replacing their helplessness with a sense of empowerment.

I have learned to include questions that may be clues to abuse in my parent questionnaire. These include sudden onset of symptomatic behavior, including anxieties, fears, nightmares, or disturbances in eating, toileting, and sleeping patterns. I learned to ask about the sudden onset of regressions or deficits, which is a clue that there may be a traumatic stressor interrupting development.

Moments of self-awareness are like little “light bulbs” that shine a new perspective on behaviors. By becoming aware of affects in the moment, the child can create a space between the triggering stimulus and the reaction and make new choices. When a child plays out an emotionally triggering event and instead of “turning the room upside down,” suddenly yells

out “chocolate milk!” and runs to the table, I see a new capacity for self-awareness and regulation. In the context of this new awareness, we can decide if we should talk about the scary feelings with a soothing drink, do more grounding and empowering physical experiences such as jumping in and out of a ball pool, or seek comfort from a parent.

Self-awareness is only possible to work on when the body becomes a source of pleasure instead of a trigger in and of itself. Talking about the body may be emotionally triggering, but using the body for pleasant sensations of soothing, mastery and competence makes it feel safer to engage in body awareness. Eventually, the child can learn to notice how quickly his heart is beating, the feeling of deep and shallow breaths, or the feeling of thirst, hunger, or urgency to use the bathroom. This heightened sensory awareness establishes the groundwork to tolerate sensations associated with trauma.

My trauma expertise has allowed me to better understand how mind, body, and brain come together in the context of a secure relationship. My practice is a DIR-informed, dissociation-informed trauma psychotherapy practice that works on enhancing attachment, attunement, and affect regulation, and promotes the growth of developmental milestones while allowing traumatic content to unfold and be processed in a safe environment.

CASE PRESENTATION BY CHEVY SCHWARTZ LAPIN

To illustrate how the DIR/Floortime model was influenced by supervision on dissociation-informed trauma therapy (Silberg, 2013; Waters, 2016), I (CL, second author) present the case of Joey.

Through his story, we hope to clarify how supervision on dissociation-informed trauma therapy enriched the DIR work and how both were integral to Joey’s healing.

I had been working with Joey and his family from the time he was age 2 until age 7. His parents came to my clinic privately for Floortime sessions after Joey was diagnosed as displaying symptoms consistent with the Autism Spectrum Disorder. As part of the intake process, I observed the parents interacting with their child without my intervening.

For the most part, Joey seemed to be in his own world. He seemed obsessed with cars but did not drive them anywhere. He rarely acknowledged his parents and seemed to avoid any type of interaction. When they were successful in engaging him, it lasted for a very short time before he turned away. My observation was that he had an overreactive sensory system and was constantly in “flight” mode due to sensory and emotional dysregulation. In addition, he had severe auditory-processing difficulties, no verbal or gestural communication, and motor-planning delays.

As part of Joey’s program, I trained the staff at his preschool and developed an afternoon program to help him in the area of social skills. Joey’s

family worked with love and dedication to appreciate and value Joey as a person and to help him achieve competency. Fortunately, Joey consistently progressed in all areas.

I always wondered about Joey's true diagnosis; I felt he was misdiagnosed and that his primary diagnosis might be SPD (Sensory Processing Disorder) and not Autism. At the time that we stopped therapy, he was entering first grade in a special program for high functioning children with similar diagnoses. Joey was now communicating his thoughts and feelings, was independently dressing and even preparing simple recipes, as well as symbolically playing out various roles in imaginative play. He had a sense of humor and could stand up for himself in his close peer group. Most of all, he had warm loving relationships.

At the same time, he still had significant delays in the areas of sensory and emotional regulation, overall delayed development and he still had unexplained "accidents" and evident anxiety. When overwhelmed, he still tended to go to the "safety" of his cars, lying on his stomach, lining them up, seemingly a way to shut out the world. Overall, although he was less fearful of relationships, he still had difficulty maintaining eye contact and seemed to be so engrossed in what he was doing that he did not respond to the outside world. I understood this as difficulty with sensory motor delays, emotional reactivity, and difficulties with multiprocessing.

A year after terminating therapy, Joey's mom called me and said that Joey requested to return to therapy with both his Mommy and Daddy. We resumed therapy, and in the familiar safety of Floortime, Joey began to play out some bizarre scenarios. It became apparent that he was describing being abused and tortured. However, he did not name the abuser. His parents were concerned that it was possibly happening during the hours that he was in school, and they immediately removed him from school. I presented Joey's case to the educational placement office, together with a psychiatrist's report confirming the likelihood of abuse. Joey's parents got permission to set up a home-schooling program.

Joey presented with somatic pain in his knees, regressed behavior, high vocalized laughter, and mimicking of an evil voice that said things like "Good, good, that it hurts you." He also would hit himself. I had never seen any of these behaviors in Joey before. In addition, the same old familiar behaviors as listed when he entered first grade continued to present themselves.

At some point, however, these familiar behaviors took on a different meaning. He had just played out an adult figure putting a child's head in the toilet and the next thing we knew he was back to lying on the floor with his cars. Normally, thinking of his response as a reaction to a feeling of overwhelming emotion, I would have said something like "Joey, that was so sad for you, thinking about such a mean thing" and he would have most probably followed the pattern and with his head down, mumble "yes" or

"I don't want to talk about it." However, suddenly I thought of his turning to the cars as a dissociative process and I said, "Joey, you are here in my room with your Mom and Dad and you are safe. Come sit up and stay with us." Joey's response was different than in the past. He looked up and saw that we were encouraging him to keep his eyes focused on us in the here and now, and he stayed with us without going back to his cars! At that point he was ready for our empathy, and was able to take the time to feel safe and loved and continue to talk about his experience. From then on I had a new understanding of his "flight response"—I could keep him in the relationship when his mind and body wanted to escape the present, and then our interventions could be more effective.

In thinking about Joey's behavior in terms of dissociation as opposed to a diagnosis of Autism or SPD (Sensory-Processing Disorder), I began to rethink the structure and goals in therapy. The first goal was to integrate grounding as part of safety and to support his staying related and focused. Instead of thinking about his play as repetitive with difficulties in motor planning, I saw it as entering a posttraumatic state where he felt compelled to play out scenarios of harm. As we worked on helping him stay grounded in therapy and at home, we began seeing less and less dissociation—that is, escape into obsessive car play, trance states, and avoidance of eye contact. Whenever he would go onto his stomach, we encouraged him to notice where he was and whom he was with. He'd then climb onto Mommy's lap, calm down from the distressing memory, and continue to play or talk about the memory.

I learned to focus on the "transition moments" (Silberg, 2013), the moments preceding flight into dissociative responses. By bringing these switches to Joey's attention, we gave him the ability to think about alternative responses and heighten his awareness. Often I would suggest to Joey that he tell Mommy or Daddy later on in the evening what was so troubling about the distressing feelings he had experienced in my office right before his retreat into "truck play." On many occasions, as Joey lay in bed, he accessed memories and shared them with his parents.

I began to think about Joey's "autistic behaviors" as changes of states. Now, instead of assuming that all strange behaviors were based on his delay, I began to wonder out loud with him what was going on. I noticed that he often picked his nose and realized that he did this after or during a difficult discussion. On one occasion, I encouraged Joey to use a tissue, first playfully and then seriously. Joey refused. I asked him if he HAS to pick his nose or wants to. He said he "has to". I asked him what would happen if he didn't and he said, "They will chop off my head." I invited him to draw a picture of who tells him that he must do this. He drew a man with a long stick and himself. I then asked him what he wants to tell this man and he

said: "I DON'T HAVE TO PICK MY NOSE!" He wrote those words on the picture. He was glowing.

Eventually, Joey was able to tell us that the perpetrators had threatened to kill him if he told about the abuse. He wrote the words "Don't tell" on a white board, and then drew an x over them as his mother and I acknowledged that "Yes, he could tell." In further discussion, he identified other internal voices that compelled him to harm himself or engage in other regressive behaviors. Ultimately, we learned that other regressed behavior such as accidents and drooling related to internal voices to which he felt compelled to listen. By engaging his awareness of this and encouraging communication internally, these behavioral regressions subsided.

Through this method, Joey developed self-awareness about his own dissociated sense of self and the roots of his self-harming and regressive behaviors. Through learning that he had a choice over these behaviors, he was able to choose not to do them. He began to understand the conflicting ways that he viewed himself and how he could choose to do more acceptable things that did not involve self-disparagement or self-harm while honoring his feelings of conflicting selves and conflicting impulses.

Joey now shares his confusion related to his attachment to the perpetrators. He has other questions as well, such as, "WHY???" "Why did this person do this to me?"—the philosophical questions one often begin to see in the late stages of processing trauma (Silberg, 2013).

Joey still has memories that will need processing and many gaps within his memories, but the dissociation and trauma-informed approach to his apparent autism allowed us to reveal Joey's hidden potential for higher levels of thinking, competency and independence.

Although Joey's therapy continues to have many elements of the Floortime model, the assessment and intervention were enriched with the knowledge of a dissociation-informed approach to trauma therapy.

Joey's affect completely transformed to being open, vibrant, curious and happy. He learned to cry and to let himself be soothed. In twelve years of working with the autistic population, including being a principal of an elementary school for 40 children on the spectrum, I had never seen a child with such inconsistent "autism." We wonder if the changes seen in Joey through this therapy approach might be possible for other children on the spectrum whose development may be impacted by trauma.

Joey's transformation was facilitated by the powerful early work in Floortime that established the environment of attachment and attunement, and the parents' capacity to continue that bond throughout the treatment as they understood the pain of his emotional world.² Joey's parents continue to be an inspiration for the power that a parental relationship has in healing even the most terrible wounds.

CONCLUSION

After my initial observation of the practice of Chevy Lapin's and my introduction to Floortime, I (JS) expressed my reaction in a comment in a final consultation report . . .

"I believe that the use of Floortime to uncover abuse is actually an innovation that the world needs to know about. . . we should examine what about Floortime enabled these young, seemingly developmentally delayed children to open up. I believe it is the very primal connection to affect and the building of attachment. I believe this needs to be central to the model that we use in treatment. I think this is an innovation. And there is no exact protocol I have come upon besides this one to assist young developmentally delayed and severely traumatized children, some of whom may be nonverbal at the start of therapy."

Dr. Joyanna Silberg

Both authors are enriched by this collaboration, and expect that our practices will continue to be enriched in the future as we share the important work we are doing with severely traumatized and dissociative children. We hope that other clinicians reading this article will become curious about the DIR/Floortime model and be open to new perspectives and collaborations that will enrich their skills and the field's collective commitment to our clients' growth.

Even therapy developed specifically for young traumatized children such as Child Parent Psychotherapy, CPP (Busch & Lieberman, 2007), although evidence based and extremely beneficial for traumatized children, may be missing some elements for treating a cohort of children with severe developmental delays, trauma hidden from the families' awareness, or profound dissociative symptoms.

For example, in the CPP model the parents are encouraged to help create a narrative with the child and to help use words or play scenarios to describe the child's experience. In the cases in this cohort, the exact nature of the abuse was difficult to reconstruct, and the children's developmental delays in symbolic play made this kind of work impossible initially. Also, CPP does not directly address dissociation manifest in the child hearing the internal voices of perpetrators, or severe primitive and dissociative responses, such as collapse or dissociative shutdown.

Although CPP addresses attachment directly, the purposeful manipulation of the attachment relationship by perpetrators who apparently groomed the children to reject parental authority led the children to present in unusual ways that do not fit conventional paradigms of the development of attachment—children stating, for example, that they have a different mommy, and this mommy is not the real one. In these cases, it was very difficult to understand the child's actual experiences. What the children

experienced was not evident initially to the parents or the therapists, and their profound developmental delays and attachment difficulties were not at first clearly discerned as trauma related. The ideas developed here may supplement existing practices like CPP and dissociation-focused trauma therapy by combining elements from multiple perspectives, including the important contributions of DIR/Floortime.

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ENDNOTES

1. Readers will certainly wonder whether law enforcement has now been able to follow up on these disclosures, now that more therapists have heard the information. As we know, validating disclosures of children with these kinds of disabilities is very difficult. However, as more therapists and children came forward, law enforcement was able to utilize some of the older information in their newer investigations and subsequent actions.

2. The authors thank the families for their permission to include the stories of their children which have been disguised for confidentiality.

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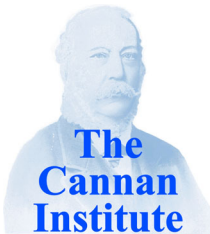
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