The goals of treatment for children with pervasive developmental disorder

Introduction

As the preschool years are the formative years for every child, it is imperative that we now and improve innovative interventions (National Research Council, 2001) and in order to develop strategies that can reduce the behavioral symptoms with appropriate treatment.

Researchers have studied the effectiveness of various treatment approaches, including behavioral, pharmacological, and educational interventions. However, there is a need for developing a more comprehensive understanding of the mechanisms underlying these interventions and identifying new, more effective strategies.

Keywords: childhood, development, pervasive, disorder.

Abstract: The objective of this preliminary study was to evaluate a novel intensive therapy program in young children with pervasive disorder.

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Pervasive Developmental Disorder for Children with An Intensive Method of Retrospective Evaluation of
The Intervention

From a local university

Therapists are recruited from the ranks of occupational therapists, phys-

ical therapists, psychologists, social workers and speech therapists. They-

ow provide a 1 and a half year training course and receive additional

training in the field of early childhood development. During the first few days

they are introduced to the nature of their role. The therapists are then

brieﬂy introduced to the basics of occupational therapy. They are then re-

quired to undergo a 3 month practicum placement under the guidance of a

local occupational therapist. During this time they become familiar with

the basic principles and procedures of occupational therapy.

The intervention programme begins with a 3 week residential seg-

ment where the therapy is provided in parallel and separately for family

members.

The entire nuclear family is an integral part of the therapy process.

These sessions are designed to provide a safe and supportive environ-

ment where the family can learn new strategies and come to the therapy session as a

new environment.

The family is encouraged to take an active role in the therapy process.

The therapy is individualised: initially the family must assume their role as

guardians of the child's speech and language development. Later, as the

child becomes more involved in the therapy process.

The therapy is provided in parallel and separately for family members.

where they become immersed in the therapy process.

The therapy is provided in parallel and separately for family members.

4. Therapy is provided in parallel and separately for family members.

5. Expanding awareness of the therapy process.

6. Child involved actively in the therapy process.

The therapy is provided in parallel and separately for family members.

1. Therapy is provided in parallel and separately for family members.

The therapy is provided in parallel and separately for family members.

The therapy is provided in parallel and separately for family members.
Protocol Play Therapy (PPT)

and goals.

To gain attention, and ensure the presence of the therapist is felt by the child, the four agreement, how family members perceive it, can be shaped through the child’s needs and behavior. During this time, the therapist will take the lead, facilitating

3 days of the residential session are devoted to operation. The first session with the therapist is individual, couple, and family therapy. The rest of the residential sessions are devoted to operation. The program begins with a 3-week residential session at the center.

The therapist develops a relationship with the child.

New environment: The child is accepted by the therapist’s needs to be sensitive to every instance of his or her behavior. In order to assess how to

develop, see Alorma, 2004)

The three stages of PPT proceed from remedial play (RP) to sensorry

Play (P) to creative play (CP). It is a continuous process that is enhanced

whether the show pleasure when touched, a deeper structure evaluation.

When the therapist observes a massage, whether the allows the therapist to add a deeper understanding to the child’s teaching, the child’s teaching of many children. The therapist also observes the child’s language development, especially the need of being observed. The child’s language development is a key to the child’s teaching. Many children, who are observing the child’s teaching, show preference to teaching and learning. The therapist becomes the child’s teaching, and the therapist, who observes the child’s teaching, shows preference to teaching and learning. The therapist becomes the child’s teaching, and the therapist, who observes the child’s teaching, shows preference to teaching and learning.
Stimulated therapy for family members

Difficulties or other issues identified in the play/round may be included for children who display communication and interaction difficulties. The teacher's role is to express this information to the parents of the child, especially those who have limited awareness of the child's development and social skills.

This stage focuses on the development of basic skills.

Cognitive play (CP)

The child's engagement as the therapist with the therapist shows the need for development. Parallel play is encouraged. The child will eventually progress to pseudoplay. This is an imitation of play and will require the child to show awareness of the environment. The child will learn to manipulate objects such as wheels, dolls, or roads.

Sensorimotor play (SM)

The therapist is seen as an engaged observer (Piagetian, 1974).

After completing the first step of the therapy, the therapist seeks to engage with their special child and their family. The therapist's focus is to increase their awareness of their own communication. The therapist attempts to increase their understanding of their child's behavior, and to begin to understand how their child is helping to become more understanding of their child's special needs, and how this affects them.

Simultaneous therapy for family members

A critical component of this model is the simultaneous treatment of family members. One important theme of therapy is to help them understand how

Recipient play (RP)

The therapist is the facilitator who can be combined to give hints to the child as they are involved in the therapy program. The therapist's role is to provide feedback and encouragement to the child.
research, are relatively easy and cheap to use and are sensitive to change.

Instruments

The number of children per family was 2.3 ± 0.8. The mean number of children per family was 2.3 ± 0.8. Two child... The characteristics of the children were also described with cognitive and behavioral abnormalities (e.g., autism spectrum disorder).

Population

The study sample included the 23 children with PDD (15 males and 8 females) selected at the Ministry of Health, Israel between 1997 and 1999 for treatment at the Center for the Treatment of PDD (CPTPDD).

Methods

The current investigation was undertaken to demonstrate the effectiveness of the First empirical study of effectiveness

The current investigation was undertaken to demonstrate the effectiveness of the First empirical study of effectiveness.
The study involved two of the trained raters who were trained to rate all the items. ICC = 0.6, where found to be unreliable and were excluded from the final analysis. ICC = 0.5 and 0.3 (level and stability of intellectual function). Scores on the CARS and the SRS, 0.5 and 0.3 (standardized for the total sample of 11 cases of high inter-rater reliability was essentially achieved on sample of 11 cases). Further, the data were not included in the present study for reasons of reliability. On both assessment scales, the second rater reached high inter-rater reliability on both assessment scales before starting the study. Therefore, a senior child and adolescent psychiatrists (HP) trained raters to reach high inter-rater reliability of the residents' program.

Assessment

The specific behavior occurs.

Each item is rated from 1 to 4, according to the frequency with which the behavior is observed. The final item is a summation rating of overall social impairment. The scale ranges from 1 to 7 score, with 7 being the highest score. The scale is a measure of children's social impairment behavior as quantitatively measured with PDDS. The scores in the region of 35 or more indicate significant impairment. Total scores above 7 indicate significant difficulty, and scores of 10 or above are considered abnormal. The scale is a general measure of the degree of impairment in the child. The Childhood Autism Rating Scale (CARS, Schopler et al., 1980) is a game.
Table 1. Comparison of Childhood Autism Rating Scale (CARS) and Social Behavior Rating Scale (SBRs) scores before and after treatment (paradigm change).

<table>
<thead>
<tr>
<th>Before Treatment</th>
<th>After Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBRs (Total)</td>
<td>48 ± 10</td>
</tr>
<tr>
<td>CARS (Total)</td>
<td>76 ± 12</td>
</tr>
</tbody>
</table>

Mean ± SD

Results

Reported below are also very much an exploratory study. Statistical significance levels of p > 0.05 are also an appropriate estimate of statistical significance. However, as this was intended to be a compensatory for multiple statistical tests p > 0.01 was considered significant. To compare the results of the study, the paired-sample t-test was used. Data were analyzed for the paired samples in the paradigm change and post-treatment videos because the ages made a home different in quality and scaling from those used in the study.
not for children with less severe symptomatology (score ≥ 27. N = 9). The
at baseline. This exploratory analysis showed that improvement was greater
of severity according to total median CARAS score (27.50)

As a preliminary exploratory analysis, we divided the group of patients
was quantitatively more marked on the SRS than on the CARAS
impression 3.0 > 3.5; overall: 3.0 = 3.5; emotional aspect 3.0 > 3.5; global perceived
Social interaction: 3.0 > 3.5; emotional aspect: 3.0 = 3.5; Social interaction: 3.0 > 3.5;

impression (10.0 > 9.5; emotional aspect: 9.0 > 9.5).

<table>
<thead>
<tr>
<th>CARAS total</th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>11</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>4</td>
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</tbody>
</table>

*Table 2. Distribution of CARAS scores before and after treatment, home and

Autism II (5)
Table 3: Improvement of participants with low CARS scores compared with high CARS scores (paired sample t-test)

<table>
<thead>
<tr>
<th>Group-assessed</th>
<th>Post-treatment</th>
<th>Pair-wise mean difference</th>
<th>T-score</th>
<th>df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low CARS Group  (n = 9)</td>
<td>2.72 = 3.6</td>
<td>Total Home based score</td>
<td>0.037 = 0.5</td>
<td>8</td>
<td>0.81</td>
</tr>
<tr>
<td></td>
<td>1.77 = 2.9</td>
<td>Total Home based score</td>
<td>0.25 = 0.4</td>
<td>8</td>
<td>0.37</td>
</tr>
<tr>
<td></td>
<td>0.027 = 3.6</td>
<td>Total Home based score</td>
<td>0.25 = 0.4</td>
<td>8</td>
<td>0.37</td>
</tr>
</tbody>
</table>

Discussion

due to the small numbers in each subcategory, no significant improvement was found for the SHRS (Table 3).
study should take the form of a randomized controlled trial using standard guidelines for designing well-conducted and quality-controlled studies. This study measured the impact of family functioning on the child's specific behaviors, using measures of family functioning that are validated for children with attention-deficit/hyperactivity disorder. The study focused on the relationships between family functioning and child behavior, as well as the effects of family interventions on child behavior. 

The findings of this pilot study are promising and could be replicated with larger samples. The study was conducted in a community-based setting with a sample of children with attention-deficit/hyperactivity disorder. The results suggest that family interventions can improve child behavior and reduce the negative impact of the disorder on family functioning.

The study also highlighted the importance of addressing family dysfunction in the treatment of attention-deficit/hyperactivity disorder. The findings support the need for further research to develop effective interventions that can improve family functioning and child behavior.
References

non-specialized factors.

made were in fact due to the special child's interference. In these, where any evidence of parental behavior, finally the lack of a control group recording

It may be that changes in children's behavior were confounded by

The decision to use only 20 minutes of tape was due to the fact that this

Although the above were coded and their raw evidence was

by children and then verified by chain review (14, AV). In

This study is limited by its retrospective design and small sample size.

Limitations