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Appendix

Session progress feedback form

Time/ Therapist	Acceptance Of People		Eye Contact	Express Wishes By Means Of:			Initiative	Speech Sounds
				Pointing	Hand Pulling	Sounds		
From: Until: Name:	New [ ] Familiar [ ] _____ Enters With [ ] Without Food [ ]	^ V 0 10 1 9 2 8 3 7 4 6 5	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	Screams<> Syllables 0 10 1 9 2 8 3 7 4 6 5	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Language Comprehension	Games and Cognitive Thinking				Physical Contact	Eating Habits	
	Curiosity	Concentration	Creative/Constructive			Like a-	Amount
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	Baby 0 1 2 3 4 5 6 7 8 9 10 Adult	0 1 2 3 4 5 6 7 8 9 10

Daily Functioning		Repetitive Patterning			Detachment	Comments
Personal Hygiene	Dress	State	Expression	Frequency		
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	**Frustration** **Excitement** **Boredom**		0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	

rather than teach the child and helps each family member move toward individual and mutual growth (24). A basic condition for this process is the ability to accept the child as having potential that awaits manifestation. The autistic child is a special child with special needs. This recognition enables changes in cognitive and behavioral patterns and triggers significant changes in the family dynamics. Success with minimal achievements accomplished in a brief period of intense work, strengthens optimism and enhances the family's ability to work effectively with their child. The theoretical postulations refined into the final structured program which has evolved endows comfort and reassurance that much can be done for the autistic child.

Limitations

Shortcomings of a descriptive report of this nature are vast. Firstly, recruitment of families both eager and capable to part from their immediate environment, especially when a large number of siblings are involved is not a feasible task. Thus, opposed to a randomized allocation of inflicted children, the stringent prerequisite requirements will deter certain subsets from joining this program. Furthermore the participation of the institution's directors in the selection committee, carrying the burden of choosing from a large number of applicants for admission will cause bias toward those more cooperative and understanding and who will probably benefit most. Secondly, retarded children were not members of the study group despite significant representation in the population of PDD such that this group may not allow full generalization

For the sake of brevity, obviously, behavioral disorders, medication and additional comorbidity issues were omitted since these factors do not influence the specific policy of the approach towards therapy and likewise are not the purpose of this report.

We may well be only in the middle of the road of a continuum of alterations needed to reach the finesse of a tailored program for each child with the idiosyncrasies of his condition. Nevertheless it seems evident that working upon the basis of these guidelines leads to the direction of a long term solution.

Conclusions

Positive experience using a multidisciplinary approach with highly trained personnel has been very encouraging. Results of the early intervention program have shown that a relatively short intensive intervention that addresses the needs of the child and the family has definite potential. This preliminary report should encourage others to perform an open clinical trial to further substantiate our clinical experience.

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that affect the couple's perceptions. These are identified and contribute to helpful insights into their attitudes.

- ***Non-verbal Communication:***
  Sessions are conducted with siblings using tools taken from movement and art. These expressions make it possible to observe and analyze family processes that are revealed to the family members in the course of the short-term family therapy.

4. Clinical Meetings:

Weekly meeting are attended by parents and therapists where the progress of the child's and the family's therapy are assessed and the effectiveness of the therapeutic strategy is examined. A structured evaluation form consisting of 20 parameters evaluates the process.

5. Aftercare Program:

Upon completion of treatment at the Center, the long term, second stage of treatment begins when the family returns home. Parents are requested to continue RPT at home. This requires daily sessions in a playroom prepared at home for this purpose where the child spends several hours each day with a trained therapist. The therapy sessions are gradually reduced as indicated by the child's progress. Follow-up is managed by a senior Mifne staff member assigned to each family to provide feedback from videos of the child that the parents submit to the center on a monthly basis. This strategy is phased down over an extended period, as the child's integration with peers is gradually increased.

The Mifne Center offers an eighteen month course to professionals who want training in RPT. Therapists who complete the training are then available to families who return from the Center after the residential period.

Social integration

The critical factor that will determine the duration of the home based therapy is the progress the child is making. As the child becomes more casual about social contact, he becomes more capable of communicating in a socially adaptive manner. This is an interactive process that depends upon the functional ability of each child that in some cases can take months until the possibility of joining peer groups emerge for the child. The final stage of treatment is the process of integrating the child with other children in a group. In this final stage, in most cases, a suitable mainstream nursery school or kindergarten is sought that will enable the child's social interaction. This is supervised by a Mifne therapist. The child's exposure to other children, their language and play contribute to this process, accelerate it, and help him move increasingly closer to his optimal functioning ability.

Results

The outcomes of children treated at the centre have been favorable. Despite the diversity of the referred cases, the basic program and treatment guidelines remained constant over the span of the 17 years that lapsed since the institution was founded. As mentioned, children are not diagnosed at Mifne. Of the 138 children referred to Mifne with a diagnosis of autism / PDD, 97 are attending regular school; 16 are in a special education program; 11 are still in the intensive aftercare program. Fourteen children did not complete the program. Instant improvements in communication parameters were recognized immediately following the initial intensive intervention. and were maintained or enhanced through the follow up program adhered to by the respective families. To date, families who were treated at the center still maintain contact with the staff.

Discussion

In recent years some progress has been made in the diagnosis and treatment of autism in early childhood. Nevertheless biological approaches impart little therapeutic advantage (18). Most therapeutic approaches focus on the phenomenological aspects of the autistic child and involve techniques that are intended to attain measurable progress in discrete defined functional areas such as motor skills, language, learning, and social responses (19-21). If only discrete areas of function are concentrated on, resetting the global level of functioning seems an unachievable goal (22). We assume that when therapy for the child who is diagnosed on the autism spectrum begins after age five, this is often too late to prevent the fixation of perceptions and behavior. Therefore the synthesis of early treatment that addresses the child's needs rather than his performance, and the family's perceptions of their child and their style of communication is critical. The families undergo severe emotional upheaval, similar to the processes of mourning (23). Denial, anger, guilt, and, finally, reconcilement for lack of an alternative, delay the ability to seek focused therapy. Parents typically describe how their helplessness generated a cycle that exacerbated the situation, and made it more difficult to reach the child. The basic concept underlying the therapeutic model practiced at the center views the family as an organic unit. The therapeutic approach and the use of RPT, based on the principles of a bio-psychosocial model, is an attempt to engage,

condemning bizarre expressions. The reciprocal exchanges between the two contribute to the emergence of the child's trust. Slowly and gradually the therapist is able to initiate activities to which the child reciprocates with socially adaptive responses. As the child's reciprocal responses increase, new "therapeutic channels" become available.

A. The Technique:

RPT (Reciprocal Play Therapy) is essentially adult posturing that encourages the child to discover the pleasures of human contact and communication. It presents the child with opportunities to help him discover his self. Each child is viewed as an individual who requires responses that are suited to his/her own needs. The child is accepted non-judgmentally. RPT creates a non-threatening atmosphere for the child in a controlled, predictable environment with the therapist. The child's self-stimulatory behaviors are not censured, but may initiate a playful response from the therapist. When appropriate, the therapist will accompany their 'play' with a narrative that describes the 'game' they are playing. For example, when the child walks on his toes and flaps his hands, the therapist will mock the action and may say excitedly –"wow, look, we're like airplanes", as they 'share' the activity.

The child is free to proceed at his own pace. This is intended to be an empowering experience for him. The atmosphere created enables the child anticipation to feel comfortable and safe. This leads to stress reduction, to open potential growth of trust in the adults who spend many hours with him. The child is in intensive one-on-one therapy sequentially with one of a number of different professions (occupational therapists, physiotherapists, psychologists, etc…). This takes place for the most part in a playroom specially equipped with large, soft and simple toys. The team of therapists observes the child, records his behavior and consistently monitors this process on videotape and charts. The treatment room is constructed with a large one way mirror that permits therapists to observe before and then again after their session, and allows parents too to observe the therapy. This therapy continues for up to ten hours daily including weekends. Time is determined by the child's level of functional development. Therapists alternate every 90 minutes. The objective is to motivate the child to reciprocate by seeking ways to engage him through pleasurable experiences. Inexplicably, the bond gradually developing between child and therapist, exhibits as a preference to family members. Each session is summarized using an evaluation scale (below under assessment).

The staff meets daily to discuss changes in the child's behavior. The staff members discuss with and instruct the parents on how best to shape responses that will help motivate their children to engage in normative reactions, through the pleasure of play.

B. Assessment Process:

An evaluation scale developed at the center uses a structured form completed after each session that documents the child's progress (see **appendix 1**). The various parameters plotted graphically allow the drawing of conclusions during the course of the treatment process. Progress at different times is easily assessed . Comparisons of assessments made by the various therapists at session are used to examine the reliability and validity of the indicators and their recorded observations. An adjunct to written reports is video filming at set milestones, which accumulates to form a video library serving the purpose of documentation research.

3. Family Therapy:

The family program is designed to help parents understand the basic principles of the treatment method. It serves to improve awareness of the quality of their communication. This clarity contributes to the development of their ability to improve verbal and physical interaction with their special child. It helps the parents reshape their perception of the child and their style of relating to him as he changes/progresses in treatment. For this purpose, the following tools are used:

- ***Family Assessment and Short-term Therapy:***
  The family physician, trained in family therapy, has three sessions per week with the family to work on identifying and understanding the dynamics that facilitate their relationships and the barriers that cause interference. The stress here is on intergeneration dynamics. In the course of these sessions the family's bio-psychosocial history is reviewed and the family tree is reconstructed, reaching back at least three generations. Family function data is collected and can be utilized to calculate overall function scores according to the APGAR scale and compared before and after intervention (16-17).
- ***Psychological Interview and Intervention:***
  The aim of the this procedure is: to understand the parents' personal and family history, especially their respective families' coping styles before marriage; to examine the marital and family relationship prior to encountering the specific difficulty related to their autistic child; to assess the parents' potential for coping with the challenges facing them. In most cases gross misunderstandings are revealed

disorder (1). The severe impairment of intellectual, social and emotional functioning has been considered to have a poor prognosis (2). Studies reported in the past, that fewer than 2% of subjects diagnosed with autism are free of symptoms in adulthood (3-4). The most beneficial modality, probably the most closely examined, is that of intensive behavioral treatment (5). A tempting solution is to administer a miracle drug and anticipate magical cure by its powers. These have invariably proved disappointing, such as the case of the secretin story (6-9). We have learned that there is no one specific intervention that can eradicate autism or its symptoms. A review in a major medical journal states: "No drug or other treatment cures autism..." (10) If such is the case, the stage is set to gladly welcome a therapeutic approach claiming to achieve full remission in the majority of cases.

In this paper we would like to present a structured model and report our experience with this technique used over the last 17 years. A retrospective study, completed recently, utilized a blind video examination of 23 children treated at our center for which video documentation was available at identical times (11). Comparison of scores before and after treatment demonstrated clearly significant improvement of a number of communication items.

The Holistic Rationale:

The treatment approach is based on the attachment theory that stresses the significance of human bonding. Infant bonding must be nurtured in ways that are mutually gratifying in order for the child to develop the ability to interact with his environment (12-13). The family is a living, constantly evolving organism, whose health and stability depends upon the mutual support and nurture of each of its members. When one member displays developmental maladjustments, the entire family is affected.

Method:

The "Mifne" (Hebrew for 'turning point') method was introduced in1987. The evolution of the holistic approach is the fruit of extensive clinical experience of the author (H.A), a family therapist who began her career in special education and has specialized in early childhood disorders working specifically with autistic children who were grouped together with deaf and physically or mentally handicapped children. She intuitively felt that limited brief therapy sessions with some of the children in the group were insufficient and that these individual children could benefit from long hours of intensive attention in an attempt to break through the barrier that blocked communication. A pioneer trial involving a number of months per family using intensive individual therapy showed three distinct trends: the child's stress level declines which reduces the intensity of his symptomatic behavior as the therapy proceeds; the earlier the intervention begins the more likely it is to produce better results; and lastly, treatment that includes parental involvement is more effective. This provided the underpinning for the approach to treatment that evolved into the current therapy used at our center.

Technique:

1. Admission Criteria:

Families with a child under the age of five, diagnosed with autism by a specialist at the referring medical facility, are accepted for treatment. An essential prerequisite is that the entire nuclear family agrees to take an active part in the treatment process that begins in residence at the center for a period of three weeks. This extends to a commitment to carry on working with their child in the aftercare program. At the intake interview mutual expectations are clarified. Following this, an appointment is set for the treatment, usually months ahead since all family members must be free of prior engagements during the first segment of residential treatment. A participation fee is not a condition for acceptance to the program. Philanthropic and charity entities support the center and guarantee, to those found appropriate for the intervention, finance of the therapy without discrimination.

The clinical team consists of professionals trained in the fields of special education, hydrotherapy, non-verbal communication, social work, psychology, medicine and family therapy.

2. Reciprocal Play Therapy:

The guiding principle of the treatment is based upon a number of basic assumptions: The first assumption considers learning, development, and performance as functions of contact. Accordingly, emphasis is placed on enhancing the motivation for interpersonal contact by means of unconditional, supportive and accepting responses. For this reason there is no room for structured teaching as practiced in other methods of treatment (14). The work in the playroom is not guided by criteria of success or failure and does not involve a system of reward and punishment as may otherwise be indicated (15). In the first stages of therapy the child is given the maximum control over what happens in the room that will help increase his comfort level, build his self confidence, enable him to trust the adults in his environment, and encourage him to experience a range of emotions.

The second assumption is that the autistic child's inappropriate reactions to his immediate environment serve a purpose for him. Therefore, the therapists are attentive to responses and nuances in the child's behavior, without

עורך מדור:

מאמר מקורי

A Model of Autism Treatment: Using Early Intensive and Sequential Multidisciplinary Intervention

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We certify there are no sources of support or grants concerning this article.

ABSTRACT

***Objective**: We report our experience over the past 17 years treating preschool children diagnosed on the autism spectrum using a perfected therapy program that is producing good results.*

***Methods**: Our program for treating the preschool child diagnosed on the autism spectrum is divided into two phases. Intensive reciprocal play therapy (RPT) is the initial element in the program for the individual child and respective nuclear family. This initial period of treatment involves residence at the institution and is followed by home treatment using staff supervision for an extended follow up period. The child's functional development and the family's relational behavior are modified by the operative therapeutic techniques.*

***Results**: Details of this program are described in detail. A general summary of the outcome of 138 children who were in the program indicates promising results. Normative social functioning was achieved in the majority of cases, allowing total integration into standard education systems.*

***Conclusions**: The positive experience with this modified approach that combines skilled relational therapy with family supervision is encouraging. We hope this report will motivate others to adopt a similar model and perform prospective scientific appraisal of this intervention.*

** For convenience purposes the paper uses the male gender.*

***Key words**: autistic, intensive intervention, family therapy, psychotherapy, multidisciplinary.*

A royal prince once became mad and thought that he was a turkey. He felt compelled to sit naked under the table pecking at bones and pieces of bread like a turkey. The royal physicians all gave up hope of ever curing him of this madness, and the king suffered tremendous grief. A sage then came and said: 'I will undertake to cure him."

The sage undressed and sat naked under the table next to the prince, picking crumbs and bones. "What are you?" asked the prince.

"And you?" replied the sage. "I am a turkey" said the prince. "I am also a turkey" answered the sage. They sat together like this for some time, until they became good friends.

One day, the sage signaled the king's servants to bring him shirts. He said to the prince: "What makes you think that a turkey can't wear a shirt? You can wear a shirt and still be a turkey." With that, the two of them put on shirts. After a while, he signaled them again and they brought him a pair of pants. "He said: "What makes you think that you can't be a turkey if you wear pants?"

The sage continued in this manner until they were completely dressed. Then he signaled again and they were given regular food from the table… Finally the sage said: "What makes you think a turkey must sit under the table? Even a turkey can sit at a table."

The sage continued in this manner until the prince was completely cured.

(Rabbi Nachman's stories)

Background

According to the DSM IV-TR, children with autism are considered to have one of a group of developmental disorders of brain function that have such a broad range of behavioral consequences and severity that they are collectively referred to as pervasive developmental disorder (PDD), or autism spectrum

THE ISRAEL JOURNAL OF FAMILY PRACTICE

כתב העת הישראלי לרפואת המשפחה

Volume 16 No. 132, November 2006

"Y.S. Medical Media" Ltd.
POB 8214, Netanya, 42504
Tel: 09-8641111 Fax: 09-8656965