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Combining Intervention Approaches in Occupational Therapy for Children With Pervasive Developmental Disorders

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ABSTRACT
Pervasive Developmental Disorder (PDD) is a complex psychiatric diagnostic category encompassing five diagnoses. Children diagnosed within this category present with an incredibly varied picture of skills, abilities, and limitations and may require nontraditional educational approaches, a variety of scaffolding supports, and alternative interventions. To promote the child's development and complement efforts of other team members, occupational therapy practitioners must draw from, and skillfully adapt, a variety of approaches to meet each child's individual needs. This article presents a general overview of some of the intervention strategies being implemented clinically and describes ways in which the techniques can be incorporated within more traditional occupational therapy practice.

LEARNING OBJECTIVES
After reading this article, you should be able to:
- Identify the range of domains and the many specific skill areas potentially affected by PDD.
- Identify specific intervention approaches purported to be helpful with children with a PDD.
- Recognize ways to successfully combine intervention approaches during intervention of a child with a PDD.

CHARACTERISTICS OF A CHILD WITH PDD
The American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual* (DSM) first included PDD in its 1987 edition. The most recent edition (2000), outlines five options that reflect a spectrum of symptomatology:
1. *Autistic disorder* requires evidence of a specific set of symptoms within three stated areas: impairment in qualitative social interaction; impairment in qualitative communication; and repetitive and restricted stereotyped patterns of behaviors, activities, or interests.
2. *PDD-NOS* (not otherwise specified) is a diagnostic option when individuals demonstrate some of the characteristics of autism but not in the specified combination necessary. Generally, children with PDD-NOS have better language skills (Kaplan & Sadock, 1998) and a more positive prognosis than children with autism.
3. *Asperger's disorder* is characterized by restricted patterns of behavior, interests, and activities and impaired social functioning but with age-appropriate adaptive behavior and self-help skills and an absence of delays in cognitive development and language.
4. *Rett's disorder*, characterized by a devastating developmental deterioration after an initial period of at least 6 months of normal development (Bird & Gascon, 1988), is a progressive illness, and the cognitive level of the child does not typically surpass that of a typical 1-year-old.
5. *Childhood disintegrative disorder* (CDD) is characterized by marked developmental regression in several areas of functioning after at least 2 years of apparently normal development (Kaplan & Sadock, 1998).

A wide range of functioning is contained under the umbrella diagnosis of PDD. For example, one child with Asperger's disorder may be fully able to attend to self-care needs, whereas a child with CDD or Rett's disorder may require full care for these tasks. Similarly, two children with autistic disorder may present differently depending on the combination of symptoms noted for the diagnosis. One may be a master at the fine motor task of Legos, and the other may not be able to hold an object in the hand for any functional period. The range of disability also is influenced by the severity of specific diagnostic criterion. Although two children may both have a delay in spoken language, the significance of the delay may vary greatly. One child may completely avoid other children, and the other may want to engage with peers but be unable to accomplish this desire. With so many possible combinations of characteristics and the wide range of skills noted within this diagnostic category, a full array of intervention options is required.

INTERVENTION APPROACHES
Numerous approaches purport to benefit a child with a PDD. It is important to become familiar with those interventions that can be blended within an occupational therapy session and to keep current with research examining their effectiveness. Although this article presents a number of approaches, information regarding efficacy is not explored.

Educational and Behavioral Approaches

Educational and behavioral approaches rely on adult guidance, environmental structure, and systematic alterations of conditions to provide behavior modification and specific, intensive education at the child's developmental level. Behavioral strategies specifically rely on manipulating antecedents and consequences, using reinforcement, prompting, and chaining to alter behavior systematically. *Reinforcement* strengthens a desired behavior and can be positive or negative depending on whether the behavior is performed to receive or avoid a specific consequence. Reinforcers vary from child to child; however, typical reinforcers for children with a PDD are food, objects, or preferred activities (Watling, 2001). *Prompting* strategies may be used to assist the child in performing correctly. Prompting may include gestures, verbal cues, manual cues, pictures, or altering materials to increase the likelihood of a correct response (Watling, 2001). *Chaining* steps of a task to teach a complex behavior allows a child to learn successive steps correctly before attempting the entire task. Reinforcement occurs in succession at the correct completion of each step until the entire activity is mastered. All the behavioral techniques emphasize the importance of errorless learning because errors in performance may hinder learning, and repeated errors formed into habits are difficult to unlearn.

The term *applied behavioral analysis* (ABA) often is used when discussing behavioral approaches. ABA merely means that behavior is systematically examined to determine the antecedents prompting the occurrence of a behavior. These antecedents can then be manipulated to alter the behavior (Anderson & Romanczyk, 1999). *Discrete trial training* (DTT) is a specific instructional program that relies on behavioral techniques. Each child's program is individualized and structured by the teacher and often is carried out in a one-on-one setting, giving the child the opportunity to perform the correct response during repeated trials. Prompts are given as needed, and reinforcement strategies are applied. The curriculum typically consists of a variety of tasks that initially address compliance and progress through complex activities such as self-care, writing, and social play.

Pivotal response training (PRT) is another specific behavioral intervention that has been designed to improve skills in language and play (Koegel et al., 1989). PRT methods are less intensive and structured than DTT and can be carried out easily in an inclusive, natural environment. PRT uses a pattern of cue, response, and consequence to teach pivotal skills, such as motivation and responsiveness to multiple cues (Rosenblatt, Bloom, & Koegel, 1995). PRT has no set curriculum, but it does follow a developmental sequence.

Carefully designed instruction in natural settings with typical consequences also may be used for children with a PDD. Incidental teaching uses child observation to determine opportunities for instruction. The environment is structured to allow the child greater participation, and the emphasis is on learning behaviors in a natural setting (McGee, Morrier, & Daly, 1999). Incidental teaching also uses the techniques of modeling, specific verbal prompting strategies, and natural and instructional cues. The length of time between natural and instructional cues can be manipulated and lengthened until the child can complete tasks with only natural cues (i.e., the materials presented).

The *structured teaching approach*, TEACCH (Treatment and Education of Autistic and Related Communication Handicapped Children; Mesibov, Schopler, & Hearsey, 1994) systematically alters the educational environment to increase a student's independence. The five components of the program are *physical structure, daily schedule, work systems, routines,* and *visual structure*. Physical structure includes the layout of materials and the classroom environment so that each area has a distinct purpose, and distractions are minimized. The daily schedule is a visual reminder of the day's activities and their sequence, which reduces anxiety for the child. Two schedules are used—a classroom schedule and an individual schedule—which are reviewed throughout the day. Work systems are visually structured activities that allow a child to see the sequence of a task: where to start, what to do, how many to do, and when the task is completed. Routines such as approaching tasks from left to right and top to bottom are an important feature of TEACCH. Other routines include work first then play, eat first then clean up, and check the schedule after completing each task (Watling, 2001). Lastly, visual structure, including visual instructions, visual organization, and visual clarity, allows the child with a PDD to maximize independence and abilities by relying on a strength.

Numerous other approaches exist, such as token systems, priming (Wilde, Koegel, & Koegel, 1992), peer modeling (Laushey & Heflin, 2000; Rogers, 2000), using transition objects, computer instruction (Moore & Calvert, 2000), and video instruction (Kashman, Mora, & Glaser, 2000). It is beyond the scope of this article to include a discussion of each. However, a practitioner working with a child involved in a specific program should learn as much as possible about the program, perhaps incorporating it into the occupational therapy session. Consistency with any program will improve its success.

Sensorimotor Approaches and Social Skills

Although sensory and motor difficulties are not criteria for a PDD diagnosis, widespread agreement demonstrates that they figure prominently in the symptomatology (Dawson & Watling, 2000; Mailloux & Smith-Roley, 2001; Watling, Dietz, & White, 2001). Many intervention techniques used with this population, therefore, address sensorimotor function or at least structure the sensory environment in a way that allows greater function to emerge. Difficulties with ideation and delays in language may lead to social difficulties and limitations in play skills, which are included in diagnostic criteria.

Techniques to improve social and play skills are also a critical part of many intervention programs.

Sensory integration (SI) is one of the most commonly used approaches for occupational therapy practitioners working with children with a PDD (Case-Smith & Miller, 1999). Because occupational therapy practitioners typically are well versed in SI theory via their occupational therapy curriculum, basic theory will not be discussed here. Several facets of sensory processing may need to be addressed with a child with a PDD. First, providing controlled and meaningful sensory experiences, in an effort to elicit internal organization and regulation, proves positive as a precursor to any formal teaching strategy. Second, children with a PDD have sensory needs that must be met at a greater frequency than individual intervention alone can provide. Helpful sensory strategies must be identified to occur throughout the day to assist the child with coping with any environment. Third, if the ultimate goal is to elicit purposeful responses to events within the environment, then even a simple level of adaptive response, such as efficiently registering input, is important as a prerequisite to efficiently processing and integrating that information. Initially intervention may begin here, although the desired end-product of treatment is more efficient motor planning and integration. Offering a physically and emotionally safe environment to explore, problem solve, plan body-in-space tasks, and satisfy overall sensory needs gives the child the opportunity to engage in meaningful activities.

The *Miller Method*, based on cognitive-developmental systems theory (Miller, 1991), uses "part-systems" as the units of teaching. Systems are an organized unit of behavior, and part-systems are the steps in a unit of behavior. For example, picking up and dropping, opening and closing, and turning on and off are considered part-systems in this approach. To assist a child in developing skills, the Miller Method uses a combination of motor, cognitive, and communication techniques. Rough-and-tumble play, raised or elevated surfaces, and sequenced activities are incorporated into the child's sessions. The elevated surfaces assist in improving attention to surroundings and enhancing motor planning to solve problems that are presented along the surfaces. For example, one of the elevated surfaces is a raised square with either wide or narrow boards to walk along. At each corner might be a task, a part of a task, or an obstacle to maneuver around or through in order to continue. The activities are chosen on the basis of the child's abilities, and language is an important component of each task. Therapists narrate action as it happens and use manual signs to enhance language.

The *Developmental, Individual Difference, Relationship-based* (DIR) model (Greenspan & Wieder, 1999; Wieder, 1996) is based on the idea that many of the symptoms seen in children with a PDD are present because of difficulties with motor planning and sensory processing rather than because of a primary deficit in relating. Therefore, intervention focuses on improving motor planning in addition to developing mutual attention, mutual engagement, and communication. Guidelines for interaction include following the child's lead, treating whatever the child does as intentional and purposeful, initiating greater interaction, helping the child do what he or she wants to do, encouraging the use of new toys and objects, creating a problem to be solved, blocking repetitive play, persisting in interaction, encouraging exploration and choices, adding steps to a familiar activity, and providing opportunities for symbolic play (Wieder, 1996, 1998).

The *Affolter method* relies on providing tactile-kinesthetic information during task completion, to assist a child in better understanding what is required (Bonfils, 2001). Tactile-kinesthetic information is provided by nonverbal manual guiding, with the therapist's hands over the child's like a pair of gloves. Verbal instructions are purposely kept to a minimum while the therapist's hands help the child "know" what to do. The guiding fluctuates on the basis of the child's needs. When the child is performing the task independently, no guiding is needed. As soon as the child appears "stuck," the therapist guides gently until the child takes over through his or her own problem solving of what to do next. Any functional task can be guided, and this technique works especially well with self-care and household tasks.

Social stories (Gray, 1995) are brief narratives created to describe social situations, relevant cues, and the desired responses to particular social situations. The narrative provides a preview and an illustration of a specific event, allowing for interpretation by persons who have difficulty understanding social cues or comprehending the quick exchange that occurs during conversation. Social stories should be created on the basis of a specific person or circumstance (Myles & Simpson, 1998). Descriptors of appropriate behavior should be outlined within the story, and this story should be read before engaging in the social event.

Additional techniques that cannot be included here are vision therapy (Kaplan, Carmody & Gaydos, 1996; Kaplan, Rimland & Edelson, 1999; Scharre & Creedon, 1992), auditory integration training, Fast ForWord and therapeutic listening (Frick & Hacker, 2000; Lemer, 2001; Veale, 1999), and interactive metronome (Shaffer et al., 2001) and manipulative therapies (Frymann, 1996; Lemer, 2001). Each technique requires specialized training to perform. A multitude of specific social skills training approaches also can be found elsewhere.

COMBINING APPROACHES

The creation of any intervention plan should begin with determining the desired outcomes. The desired outcomes should come directly from the evaluation and the family and other team member needs. Many of the described approaches can be combined easily or used in sequence. After a therapist is familiar and comfortable with a variety of approaches, it is important to carefully decide when to use them. Certain strategies lend themselves easily to certain outcomes. For

example, if the desired outcome is greater independence in self-care tasks, the Affolter method or certain behavioral techniques might be the most useful. If the desired outcome is improvement in play skills, then perhaps the DIR model or SI strategies might be the most successful.

Other factors should also figure into the decision, such as the family's needs and wishes; the environment; the equipment available to the therapist; the child's skills, abilities, and needs; the child's sensory preferences and interaction abilities; the therapist's own knowledge and comfort level with the various strategies; and the child's observed needs and reactions on any given day or within any given session. Timing and sequencing are key. A therapist must carefully observe the child's behaviors to determine when a certain strategy might be appropriate. Observations such as noting that a child is stuck in a routine, looking for a new activity, or withdrawing from interaction are important. The therapist must also avoid trying too many different things at once. Not every child needs every technique. By observing the child and noting what is affecting performance, the therapist can choose the appropriate technique at the appropriate time. For example, if the child becomes anxious when any demands are made on him or her and withdraws from interaction or throws tantrums, then perhaps some of the TEACCH techniques (choice boards, schedule boards, routines) or priming will reduce the stress and anxiety.

The techniques chosen will depend on the environment and available equipment. A very small room or one without much equipment is not as conducive to a lengthy movement sequence, SI intervention, or the Miller Method, for example, as a larger, better-equipped space. DIR strategies require less equipment and space and can be done almost anywhere. Many of the techniques can be adapted for use within a classroom environment. The therapist should examine the child's responses to varying sensory environments (bright vs. dim lighting, bigger vs. smaller room, more vs. less visual stimulation, more equipment and toys out vs. fewer out, music playing in the background vs. quiet) and to himself or herself (proximity, vocal qualities, eye contact, demands made). If therapist proximity is an issue, for example, the Affolter approach may not be successful.

The combinations of strategies used may vary from session to session. One day a child might need more behavioral assistance or visual structure, and another day the same child might perform better if given more of a role to lead the session with less structure. Some families may want the therapist to completely follow the child's behavioral program within the session, and others may want the occupational therapy session to be free from the behavioral program completely.

The following lists ideas for incorporating the techniques into an occupational therapy session. It is not expected, or desired, that each item would be used for every child or during every session.

- Learn the child's typical command words from the behavioral program and use them in the same way.
- Learn the child's reinforcers and incorporate them into the session as rewards for correct responses according to the program.
- Structure the environment visually and incorporate visual activities that help with attention, tracking, and eye–hand coordination.
- Label items with pictures or words.
- Provide clear boundaries on areas and clear expectations regarding what activities are completed in each area.
- Use schedule boards, choice boards, and reward boards as appropriate for the child.
- Use objects or items that motivate the child to complete less preferred or more challenging tasks. For example, hide a favorite object within theraputty or under a heavy pillow or place it on top of something to climb. Be sure the child sees where the object went and, if necessary, make sure that he or she will be able to get it back quickly.
- Visually show the number of times that an activity must be repeated (e.g., put out five pegs or five puzzle pieces, two socks and two shoes).
- Simplify fine motor and self-care activities by providing written or visual steps.
- Use a cue, response, and consequence pattern with activities that allow for it. The cue may be materials or a verbal prompt; the response is the child's reaction to the natural or verbal cue; and the consequence is successful completion of the activity.
- Use less verbal instruction and use hand-over-hand guiding for problem solving where the activity allows for it.
- Create problems to be solved that are developmentally appropriate for the child.
- Use raised surfaces to increase attention.
- Create boundaries for motion, edges to come to, objects to bump into, and spaces to play or move within.
- Gradually increase the sequences of steps that need to be completed.
- Add more steps and increase the length of visual attention needed to finish an activity, place needed items (puzzle pieces, beads, pegs, bean bags) within resealable plastic bags, plastic storage containers, or small jars that must be opened first. Objects also can be placed inside a buttoned or zipped pocket that must be opened or within a tin foil ball that must be unwrapped.
- Place pieces of the activity to be completed within an obstacle course.
- Block repetitive play playfully and encourage new play.
- Place preferred sensory activities along with challenging activities within the steps of an obstacle course.
- Discuss or read stories about what will happen before introducing a new activity or concept. Verbally or visually prepare the child for what will come next.

- Use music or singing. Sing about what you are doing in the session or sing with a beat to help the child with timing. To increase verbalization, sing and leave out the last word, allowing the child to fill in the blank.
- Use drum music in the background to help with timing, sequencing, and rhythm.
- Use a quiet time or seated activity with the child to provide manual therapy, deep touch pressure, or joint compression.
- Incorporate specific vision therapy activities into sessions as able.

CONCLUSION

As the body of information related to PDD continues to expand, so does the list of possible interventions. As practitioners supporting children and their families, we are responsible for maintaining an adequate knowledge of such interventions, including efficacy research. Many more approaches are outside the scope of this article. Practitioners must be aware of these options and integrate the appropriate strategies into more traditional intervention approaches. ■

CASE STUDY: Combining Aspects of Multiple Approaches Within an Outpatient Treatment Session

Johnny is a 3-year-old boy with autism. He is nonverbal but signs "more" and shakes his head no. He receives speech therapy and DTT in the home. He attends occupational therapy at an outpatient clinic that specializes in SI treatment. His occupational therapy evaluation was completed via clinical observation of play and parent interview, along with the Sensory Profile (Dunn, 1999). As his diagnosis would suggest, the evaluation indicated that Johnny has delays in multiple areas. His gross motor skills are a relative strength, however, and he enjoys a variety of movement experiences. During the evaluation, he demonstrated tactile and auditory defensiveness and limited play skills other than gross motor play. He was extremely frenetic, moving rapidly from activity to activity. His parents said that he always moved quickly when he played and was excited and that he rarely stopped to play with any one thing for long. Their goals for him focused on improving his play skills, attention span, and tolerance of a variety of experiences.

Johnny's therapist began intervention using primarily an SI approach. Activities initially focused on slow linear movement, deep touch pressure, and heavy work to reduce his arousal level and sensory defensiveness. She gradually increased the amount of play and interaction he was able to handle by joining him in his play and carefully adding challenges when he was comfortable. She playfully created problems and obstacles and introduced a variety of toys and objects slowly and in a nonthreatening way. Johnny loved to run in a large circle around the clinic hallways before entering the treatment room. If this activity were not allowed, the session began with a tantrum. Therefore, the therapist decided to use this "game" as part of treatment, slowly, one item at a time, building large obstacles in the hallway for Johnny to climb over or through before he could continue his circuit. Typically, the obstacles included some heavy work, such as pushing large pillows out of the way, or deep touch pressure such as climbing through a tight tunnel to help calm Johnny from this very active and playful game. She would allow five times around, counting as he went and stating, "Four more times, three more…last time and then into the room," so he was able to transition easily into the session. The obstacles were different each time around and sometimes included a "toll" that might be a challenging fine motor activity. The motivating hallway activity, which also became a comfortable routine to help begin each session, allowed Johnny to reduce his anxiety and enter the room for treatment without difficulty. By beginning each session with this activity, the therapist was able to introduce novel tasks within a familiar and comfortable sequence.

When Johnny had progressed to being able to attend to and complete multistep gross motor activities, the therapist gradually initiated techniques from other approaches.

> Johnny enters the therapy room, which has been set up to invite initial gross motor play. A tire swing is suspended from the ceiling, and a bolster is propped at the wall against a medium-sized ball pit so that it can be climbed to jump into the ball pit. Johnny immediately gets into the tire swing, which he is familiar with, and begins to jump around in a circle like a frog. The therapist is nearby and offers her hands to pull Johnny up into the air and let him "fly" like Superman. The therapist narrates his actions to put words to what he is doing. When his motion stops, she asks, "Do you want more?" and waits for him to sign more. She offers her hands again and he pulls them and lets go. Next, the therapist guides Johnny to the bolster, and he climbs up to the top. She says, "Jump in," and gestures to jump with her hand. He jumps in, climbs out the other side, walks along the 6" edge, and goes back to the tire swing. They repeat this sequence multiple times, with the therapist adding different heavy work activities each time to help Johnny regulate his arousal level and calm his body. During one repetition, she layers the top of the ball pit with big pillows that he must lift and throw out. One time she knocks down the bolster "by accident" so that he must help her lift it back up. Throughout the session, the therapist continues to narrate what is happening. "Oh no, the bolster fell. Help me lift it. Oh, this is so heavy." To add more steps, the therapist places five puzzle pieces at the beginning of the sequence and a puzzle at the end. Johnny is cued to get one piece before going through the sequence and then to place the piece into the

puzzle. After the first time, he is able to complete the sequence independently, so for the next trip, the therapist puts the puzzle piece into a resealable plastic bag that Johnny must open. The next piece is placed in a sealed plastic container. When all of the puzzle pieces are in place, the therapist removes the puzzle, adds a tunnel to the sequence, and places five small bottles filled with water and one large peg at the beginning of the tunnel. The peg-board is placed near the sink and a colander into the sink. Johnny is guided though the obstacle course to pick up a bottle before the tunnel and to bring it to the sink after the tunnel. At the sink, the therapist manually guides Johnny's hands to open the bottles, pour the water and peg into the colander so he can watch the water drain out, then take out the peg and place it into the peg-board. On four repetitions, she manually guides him only when he requires it, allowing him to complete whatever portions of this task he can do independently. The session ends with seated activities that Johnny chooses by selecting pictures of them from a choice board. He is given increasing numbers of choices from session to session and now can select from five. He chooses either two or three of the five and places the pictures onto his activity board. When each activity is finished, the picture is removed from the board, and Johnny is assisted to sign "all done." The activities include pulling "treasures" out of theraputty, stringing beads or lacing cards, prewriting and drawing with a magnetic drawing board, tracing using changeable markers to leave a visual cue when tracing is successful, and self-care tasks. When all the activities are completed for the day, Johnny is rewarded with one of his typical rewards from his behavioral program used at school.

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Combining Intervention Approaches in Occupational Therapy for Children With Pervasive Developmental Disorders

November 5, 2001

The answer card can be found bound into this issue of *OT Practice* following the test page or on our Web site at www.aota.org under Continuing Ed.

1. Children within one of the five diagnostic categories under DSM's PDD umbrella:
   A. Are all positively influenced by behavioral interventions.
   B. Demonstrate a wide variety of functioning.
   C. Are equally deficient in self-care skills.
   D. Demonstrate commensurate cognitive limitations.

2. The techniques incorporated into an occupational therapy session should be based on:
   A. The family and team's needs and wishes.
   B. The child's skills and abilities.
   C. The practitioner's ease and comfort with the technique.
   D. All of the above.

3. Which of the following statements most accurately reflects how appropriate intervention strategies are determined?
   A. Occupational therapists must decide for themselves.
   B. The family alone decides what to do.
   C. The environment and equipment available must be considered.
   D. All strategies should be tried with all children to determine the best possibility.

4. Which of the following is an accurate statement about social stories?
   A. They can be generally and universally applied.
   B. They outline the desired responses to a particular social situation.
   C. They are used to reflect back on an unsuccessful social exchange.
   D. They are not successful for older children.

5. Which statement is true about the intervention approaches and/or their philosophy as presented in this article?
   A. Practitioners must keep current with the research and efficacy of the various approaches used in the intervention of a PDD.
   B. Efficacy is clearly documented for the approaches presented in this article.
   C. Occupational therapy practitioners should only use sensorimotor approaches and let the teachers implement the behavioral approaches.
   D. All possible approaches were presented with this article.

6. Which of the following is an accurate statement about educational and behavioral approaches?
   A. They rely on adult guidance.
   B. They use prompting, cues, and chaining.
   C. They purport that both positive and negative reinforcers strengthen behavior.
   D. All of the above.

7. Which of the following approaches share basic principles of sensory integration?
   A. The Miller Method and DIR model
   B. Affolter Approach and Social Stories
   C. The Miller Method and TEACCH
   D. ABA and DIR model

8. Which of the following can be easily carried out within a typical classroom or natural environment?
   A. DTT
   B. PRT
   C. Miller Method
   D. Sensory integration

9. Which of the following approaches is most effective for addressing tasks related to self-care?
   A. Social stories
   B. PRT
   C. Affolter Approach
   D. Sensory integration

10. Which of the following is true about determining when to implement a specific strategy?
    A. It should be determined before the child arrives for the occupational therapy session.
    B. It should not deviate from the initial plan of action.
    C. It should depend on the success rate when another discipline implements the approach.
    D. It requires careful observation of the child on any given day.

11. Behavioral strategies are difficult to implement during occupational therapy sessions because they are not consistent with traditional occupational therapy approaches.
    A. True
    B. False

12. Which of the following is an accurate statement with regard to the PDD diagnostic category?
    A. The diagnostic options presented in the DSM under the PDD umbrella term have been consistent since 1987's third edition.
    B. The range of functioning reflects the array of potential criterion and the extent of severity that each of these criteria can present.
    C. It is generally accepted that the prognosis for children with PDD-NOS is similar to that of children with autism.
    D. Delayed or impaired language functioning is a consistent characteristic of the five diagnostic options under the PDD umbrella.