Alia for Early Intervention

For a brighter future!

جمعية البحرين للأطفال ذوي الصعوبه في السلوك و التواصل

Bahrain Society for Children with Behavioral & Communication Difficulties

There are some immediately recognized advantages of Berard AIT:

- it only requires 10 days, with two 30 minute listening sessions each day.
- the main pre-requisite skill is that the listener must accept the head-phones (Berard Practitioners are knowledgeable about how to help those individuals who may be initially reluctant.)
- it can be provided as young as 3 years of age.

Please read more on http://berardaitwebsite.com

We shall begin this years AIT Sessions routinely throughout the year.To register your child you must:

1. **Perform the Ear Check Before Berard AIT- See attached sheet**
2. **Fill in the form below**
3. **Fill in and hand in the PRE-SCREENING EVALUATION FORM if this is the first time your child is doing AIT.**

Fees for Berard AIT – One hundred Bahrain Dinars.

Yes! I am interested in registering my child for Berard Auditory Integration Training.

Student Name:_____

Guardian/Parent Name:_____

Signature:_____

Application Received on:_____/_____/_____

DD MM YY

Alia for Early Intervention
Auditory Integration Training
Building 5 Road 1115 Block 611 *autism@batelco.com.bh*
Kingdom of Bahrain *Phone:+97317730960*

AIT PRE-SCREENING EVALUATION FORM — NEEDS ASSESSMENT

Date:_____

Name (include nickname) __ _

Date of Birth __ _ _ _ _ _ _ _ _ Age _ _ _ _ _ _ _ _ M/F _ _ _ _ _ _ _ _ _

Parent/Guardian's Name__ _

Address _

_ _

Home Phone __ _ _ _ _ _ _ _ _ _ Work Phone _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

How did you find us?__ _

Diagnosis: _

Reason for inquiring about auditory integration training:_ _ _ _ _ _ _ _ _ _ _ _ _

_ _

1. Education: School and Grade (current or highest level achieved):__ _ _ _ _ _ _ _

Any academic problems in school? __ _

Special classes? If so, please explain __ _

2. Physical/Medical Issues: _

History of ear problems? Y / N __ _

Ear infections? Y / N (age?)__ _

Broken ear drum? Y / N (age?) _

Insertion of PE tubes? Y / N (age?) _ _ _ _ _ _ _ _ _ Date removed _ _ _ _ _ _

Antibiotic use? Y / N __ _

Allergies or food sensitivities? Y / N _ _ _ _ To what? _ _ _ _ _ _ _ _ _ _ _ _

Special Diet? _

Medications and/or Nutritional Supplements? (Include dosages): _ _ _ _ _ _ _ _ _ _

_ _

History of adverse reaction to immunizations? Y / N _ _ _ _ _ _ _ _ _ _ _ _ _ _

If so, at what age, the specific immunization(s), and what was the reaction? __ _

History of seizures? Y / N _ _ _ _ _ _ _ If so what kind? _ _ _ _ _ _ _ _ _ _ _

Brain or head injuries? Y / N __ _ _ _ _ If so, at what age? __ _ _ _ _ _ _ _ _

Difficulty with balance or coordination? Y / N __ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Difficulty with fine or gross motor skills? (handwriting, sports, etc.): Y / N __ _ _ _ _

Pain threshold: High _ _ _ Normal Limits _ _ _ Low __ _ _

3. Developmental History:

Were there any problems with the pregnancy/birth process? Y / N _ _ _ _ _ _ _ _ _
Was there more than one ultrasound done during pregnancy? Y / N __ _ _ _ _ _ _ _
Developmental milestones: Crawled? Y / N __ _ _ _ _ _

Walking: __ _ _ normal limits __ _ _ _ delayed

Talking: __ _ _ normal limits __ _ _ _ delayed

Toilet training: __ _ _ normal limits __ _ _ _ delayed

Other: __ _

4. Speech/Language and Hearing Issues (identify if current or in past):

Hearing impairment or loss? Y / N __ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Sensitivity to loud sounds? Y / N __ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

______a few sounds _ _ _ some _ _ _ many _ _ _ most sounds

Please indicate specific sounds if known: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
_ _

Hypersensitivity to quiet sounds (i.e., hearing sounds others do not hear or before others

hear them)? Y / N __ _

Does the sensitivity to sounds vary? If so, what makes a difference? __ _ _ _ _ _ _ _
_ _

Current or history of speech therapy? Y / N _ _ _ _ _ _ _ What age? __ _ _ _ _

Current language ability: _ _ _ no words _ _ _ one word __ _ 2-3 words

_ _ _ near sentences _ _ _ full sentences

Speech is: _ _ _ easily understood _ _ _ difficult for most people to understand

Stuttering or stammering problems? Y / N _

Speech abnormalities or delays? Y / N __ _

Difficulty with comprehension? Y / N _
Delayed comprehension? Y / N __ _

Difficulty with sound discrimination? Y / N __ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Especially in noisy environments? Y / N _
Difficulty concentrating/attending esp. in noisy environments? Y / N _ _ _ _ _ _ _ _

Difficulty following directions or multi-step instructions? Y / N _ _ _ _ _ _ _ _ _ _

Slow response time? Y / N _

5. Psychological/Emotional or Neurological Issues (identify if current or in past):

Depression? Y / N __ _

Easily angered, irritable or impatient? Y / N __ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Anxiety/fears/phobias? Y / N _

Attention deficit disorder? Y / N _ _ _ _ _ _ With hyperactivity? Y / N __ _ _ _ _

Obsessions or compulsions? Y / N _

Bipolar disorder? Y / N __ _

Tic disorder / Tourette's syndrome? Y / N _

Neurological issues? (specify)__ _

Other: __ _

6. Social Issues:

Discomfort or difficulty in social situations? (describe): __ _ _ _ _ _ _ _ _ _ _ _ _

_ _

Inappropriate or immature social skills? Y / N __ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Difficulty maintaining relationships? Y / N _

Is there any additional information you feel is important for us to know? Comments or concerns?

(Do not hesitate to write on the back of this page or attach additional information.)

Note: This form is strictly confidential. The completion of this form in no way obligates you or the practitioner to perform AIT. It is only to help us determine what is in the best interest of the applicant.

Alia for Early Intervention

Berard AIT Certified Practitioner SB14108

Thank you for contacting our office regarding Dr. Berard's Auditory Integration Training (AIT). At your request, we are enclosing information about the training and a registration packet.

If interested, please fill in the AIT RETURN FORM, as it indicates the necessary requirements for the Initial Processing.

Next, we will call you (or you may call us) for an Initial Consultation appointment.

Thank you.

Adminsitration Offices

AUDITORY INTEGRATION TRAINING

Dr. Guy Berard of Annecy, France, after more than 25 years of success in France, has brought his method of helping hearing anomalies to America. He developed a device which "retrains" the hearing mechanism/system.

Essentially the device transforms music by means of a variety of amplifiers and filters working within all frequencies of the sound spectrum. Low and high pitched sounds are randomly played with or without filters, through standard earphones. Volume can be regulated through each ear.

Hearing Anomolies are revealed by **Audiometric Evaluation** and treatment is based on the results. The training parameters are then set as prescribed by Dr. Berard's Auditory Integration Training protocol.

Treatment consists of: **20 half-hour sessions** (twice daily for 10 days), **Audiometric Evaluations** , (midway and at the end of training)and a three month treatment follow-up and analysis is done by mail.

Dr. Berard feels that his Auditory Integration Training can help many different problem areas such as Autism, Reading, and some Language related problems. In addition, children who are hypersensitive to sound or have problems focusing or attending to sound, can be helped.

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For a consultation or more information contact:

Alia For Early Intervention

AUDITORY INTEGRATION TRAINING (AIT)
FREQUENTLY ASKED QUESTIONS

WHAT IS AUDITORY INTEGRATION TRAINING (AIT)?

Dr. Berard's Auditory Integration Training (AIT) works on the principle that if sound has been partially blocked or becomes painful, successive flexing and xtensions of the middle ear muscles will increase mobility and decrease pain. This stimuli influences portions of the brain which correlate with the auditory pathways. When alternating low and high pitched sounds are introduced randomly to the auditory system, blood flow to the area is increased and the brain is also stimulated, thereby adding to the overall positive effect. This principle then is based on mechanotherapy, i.e., improvement by mechanical means.

WHY DOES AUDITORY INTEGRATION TRAINING (AIT) WORK?
Dr. Berard explains that the (AIT) sessions exercise the muscles in the middle ear cavity. The treatment apparently strengthens the muscles and improves the body's reaction to sensory overload. He feels that at some point in the person's life (in-utero, at birth, or after birth) something occurred to inhibit the body's normal reaction to sensory auditory overload and the body has not recovered.

The brain, when deprived of age appropriate stimuli, does not work to capacity. By stimulating the auditory areas of the brain, the auditory cortex reorganizes and improvement is noted. Research with animals demonstrated that the brain has the capacity to shift thresholds and rearrange circuits. It is suspected that the stimulation of the auditory areas with Dr. Berard's (AIT) helps with the threshold shift.

WHAT DOES (AIT) INVOLVE?
Not everyone benefits from (AIT). Therefore, the Initial Consultation is extremely important to the process. The client, parent or guardian must fill out an extensive questionnaire that will be discussed at the Initial Consultation. Dr. Berard's strict protocol requires that the Initial Consultation include a **"Berard" audiogram** (additionally a mid and final audiogram are necessary), other special auditory tests and discussion specific to the client's functioning in everyday life. If the client is considered a candidate for (AIT), sessions can be scheduled.

(AIT) consists of 20 one-half hour listening sessions using the Audiokinetron device invented by Dr. Berard. Various music selections are chosen for their broad sound spectrum, energy, and intensity. The Audiokinetron randomly selects high and low pass filters and amplifies and/or filters the frequencies along the sound spectrum as indicated by the results of the **"Berard" audiogram**. The participant listens to the music through special headphones.

Sessions are twice a day for 10 days and must be separated by a minimum of three hours and extend over a two week period which can be separated by a weekend. The second **"Berard" audiogram** is performed after the first 10 sessions and the third after the 20th session. Follow-up is done after three months with a special questionnaire and analysis.

Also being used is a new generation AIT device (exempt by the FDA), called Digital Auditory Aerobics (DAA). The DAA unit utilizes the same principles as the Audiokinetron.

In order to achieve maximum effectiveness, no new learning should take place in between sessions. This means if the client is in school during (AIT), no new academics should be taught or remedial activities attempted. Camp should also be avoided during sessions. Physical activity, coloring, watching TV or movies, reading a book and similar activities can be considered if done in a relaxed manner. Stressful activities should be avoided. If an adult is working, it is best to "take a vacation" for the two weeks of (AIT).

WHO CAN BENEFIT FROM (AIT)?

Dr. Berard, after years of research has noted that (AIT) can benefit many people with disorders that directly or indirectly are affected by their hearing. Common problems may be Autism, some Learning Disabilities including Dyslexia, Attention Deficit Disorder, Pervasive Developmental Disorder, Central Auditory Processing Problems, Fluency Problems, Hypersensitivity to sound (certain sounds are too distorted or loud), and Hyposensitivity to sound (may not be as responsive to certain sounds).

Alia for Early Intevention

AIT - REGISTRATION FORM

PARTICIPANT:

NAME:_____DATE OF BIRTH:_____AGE:_____

PARENT/GUARDIAN

NAME:_____HOME:_____WORK:_____

ADDRESS:_____

DIAGNOSIS/CLASSIFICATION:_____

How did you hear about Auditory Integration Training?_____ How did you hear about ALIA FOR EARLY INTERVENTION? _____

Has an Audiogram been performed previously? _____ If so, please bring a copy with you.

Please list any special medical conditions and medications _____

When attending training, will you be commuting or staying locally?____
If commuting, please indicate travel time one way:_____

AIT - CASE HISTORY

Form Completed By:_____Date:_____

Please fill in this questionnaire carefully. You may have answered some of these questions previously, however, each form has a specific purpose, so please provide the information again.

A. Identifying Information:

Participant's Name :_____DOB:_____Age:_____Sex:_____

Referred by:_____

Reason for referral: _____

MOTHER/GUARDIAN ---- FATHER/GUARDIAN_____

Name :_____Name:_____

Address_____Address_____

Home Tel:(_____)_____Home Tel:(_____)_____

Date of Birth:_____Date of Birth_____

Marital Status :_____Marital Status:_____

Level of Education Completed: _____Level of Education Completed :_____

Occupation: _____Occupation:_____

Place of Employment: _____Place of Employment :_____

Days/Hrs_____ Days/Hrs_____

Work Tel:(_____)_____ Work Tel:(_____)_____

Siblings and Ages:_____

Languages Spoken in Home: _____

Child's School: _____Town: _____

Days/Hours Attended :_____School Tel:(_____)_____

Grade Level: _____Classification:_____

Any other family members classified or have learnng problems?_____

Pediatrician:_____Tel:(_____)_____

B. Medical History:
Has your child's health been: _____Excellent _____Good _____Fair _____Poor

Has your child had any of the following:
Tonsils Removed _____Age_____After Effects_____
Adenoids removed _____Age_____After Effects_____
Ear operations _____Age_____After Effects_____
Myringotomy Tubes_____Age_____After Effects_____

List any accidents or injuries your child has experienced?_____

Is your child on any medications? _____If so, what? _____

Has your child had any prolonged high fevers?_____If yes, under what circumstances_____

Has your child ever had frequent colds?_____Ear Infections?_____If yes, please check how many between the ages of : 0-2_____ 2-3_____ 3-5_____5+_____

Has your child been diagnosed as having any congenital or genetic conditions? (i.e., Cerebral Palsy, Down's Syndrome, other)_____

C. **Speech, Language and Hearing Development** :
How old was your child when he/she:

Used speech-like sounds?_____Spoke his/her first real word?_____

Began putting words together?_____Approximately how many words were in your child's vocabulary at 18 months?_____ at 2 years?_____

Did your child ever use gestures to accompany speech?_____To replace speech?_____

Has your child ever been ridiculed, shamed or criticized about his speech?_____

Does your child have a tendency to repeat sounds or words often?_____How do you respond? _____

How does your child seem to feel about his/her speech? _____

Describe your child's speech and language as it is now: _____

Does or Did your child:

_____Babble
_____Hesitate and/or repeat sounds
_____Respond to background noise
_____Show fear to sound
_____Have difficulty following directions
_____Talk too fast
_____Use gestures to communicate
_____Respond to only one sound
_____Seem to ignore sound
_____Use no speech
_____Use speech incorrectly
_____Talk too loud

D. Education Development

Describe your child's reading skills_____

Does your child have difficulty with (Please check)

_____reading _____phonics _____memory _____following directions _____other academic areas
(Please describe)_____

How does your child interact socially with peers?_____

With Adults?_____

Thank you for the above **CONFIDENTIAL** information. We look forward to working with your child.

Referral Information

How did you learn of our services?

_____Physician referral _____Former Client _____School Referral

_____Yellow Pages _____Speech Pathologist _____Audiologist

_____Advertisement _____Word of Mouth _____Other :_____

AIT - INITIAL QUESTIONNAIRE

PARTICIPANT'S NAME: _____DATE:_____

(Please Print)

(Questions should be answered from the point of view of the Participant)

If old enough, the participant should answer the questions. If the participant is a child, the parent/guardian can answer the questions as though responding for the participant. All questions have a purpose so **please answer all questions** , whenever applicable, to the best of your ability. All responses are confidential. Use the back of the form when necessary.

GENERAL QUESTIONS :

1.Has anyone described you as aggressive?

2.Do you have periods when you feel depressed?

3.Do you find yourself feeling unhappy or sad frequently?

4.Do you feel that you are an anxious person?

5.Do you ever feel lethargic (lazy or indifferent)?

6.Do you cry easily?

7.Do you like to read?

8.Are you a picky eater? If yes, which foods do you **not** like to eat?_____

9.Is it easy for you to express yourself?

10.Are most sounds uncomfortable to you?

11.Are some sounds uncomfortable to you?
If so, which ones? _____

12.Is sound ever painful to you?

13.Do you enjoy listening to music?

14.Are you uncomfortable with headphones on?

15.Do you feel that one ear hears better than the other ear?

16.Do others feel that you are slow to respond to what was said to you?

17.How long can you stand listening to something that is interesting to you?

18.Do you have trouble following directions?

19.Do you have a short attention span?

20.Do you learn best with your **eyes** or **ears** ?

21.Do you have a history of middle ear infections?
If yes, how many?_____

22.Do you bump into objects easily?

23.Do you trip and fall easily?

24.Do you now, or have you ever, had allergies?
If so, are they related to food?_____ Or environmental?_____

25.Do you have asthma currently, or in the past?
_____current _____past

26.Do you have circulation problems?
Are your arms or legs ever numb or cold ?_____

27.Do you hear ringing, buzzing, or noises in your ears?
If so, for how long?_____

28.Do you now, or have you ever had a speech problem?
_____current _____past

29.Do you stutter or stammer?

30.Do you have problems sleeping?
If so, please describe_____

31.Do group situations bother you?
If so, please describe_____

32.Do you like to be by yourself in a quiet situation?

33.Is your handwriting easy to read?

34.Have you ever had trouble learning? If so, in what area, and how did it affect you?_____

35.Are you right or left-handed?

36.Do you like hugging family members?

37.Does tight clothing bother you?

38.Do you mind getting your hair cut?

40.Do you feel rules of behavior are important to follow?

FOR ADULT PARTICIPANTS

1.Are you married?

2.Do you smoke cigarettes?

3.Do you drink alcohol or beer? _____socially _____daily

4.Have you ever been addicted to drugs?

5.Has a physician ever prescribed medication to help you sleep or calm your nerves? If so, which medication(s)?_____
How long did you or are you using it/them?_____

6.Have you ever experimented with drugs?

7.Have you ever worked in noise?

8.Have you ever used guns?

9.Have you ever had your hearing tested?
If so, what were the results ?_____

10.Do you "fit" in with those around you?

11.Is your behavior accepted by those around you?-------Do you care_____

12.Have you ever considered suicide?

PARENT/GUARDIAN RESPONSES FOR CHILDREN

1.Does your child have temper tantrums?

2.Will your child follow directions easily?

3.Does your child behave better at school or at home?

4.Does your child let you know his needs? How?_____

5.Does your child separate from you easily?

6.Are other people able to understand your child?

7.Did your child talk at a normal age?

8.Has your child's teacher expressed concerns about:
(please check were applicable)

___speech/language ___attention span
___listening ___aggression
___following directions ___isolation
___learning in general ___reading
___spelling ___math
___interacting with others

9.What do you like best about your child ?_____

10.What do you feel your child's biggest problems are?_____

AIT - INITIAL CHECKLIST

PARTICIPANT'S NAME:_____

AGE:_____DATE:_____

In order to determine appropriate candidates for Auditory Integration Training (AIT), we need to examine a number of different categories. There is no score. The checklist simply serves as a guide to identifying possible candidates for treatment. Please check the areas, which describe the participant. If extra comments are necessary, please use the back of the form and make a note on the front.

RECEPTIVE LISTENING/LANGUAGE

____appears to "tune out"
____short attention span
____easily distracted by noise
____oversensitive to some sound
____difficulty with sound discrimination
____difficulty understanding group discussions
____poor memory
____limited eye contact
____long response time to input
____answers questions inappropriately
____needs repetition or clarification
____follows only 1-2 directions

EXPRESSIVE LISTENING/LANGUAGE

____unclear speech
____poor spelling
____reverses letters/sounds
____speech lacks fluency
____word usage difficult
____difficulty telling a story
____sings out of tune
____dull, flat voice quality
____poor sentence structure
____interrupts
____difficulty reading out loud
____speech lacks rhythm

MOTOR SKILLS/BODY IMAGE

____poor posture
____clumsiness
____poor sense of rhythm
____confuses location/direction
____hard time with structure & organization
____fidgeting
____confuses right & left
____messy handwriting
____difficulty using time effectively
____craves rocking/swinging

BEHAVIORAL/SOCIAL ADJUSTMENT

____difficulty making & keeping friends
____irritable
____hyperactive tendencies
____excessively tired at end of day
____immaturity
____difficulty setting goals
____poor self-image
____difficulty beginning & completing projects
____lacks self-control
____difficulty making judgments
____does not complete assignments
____lack of tactfulness
____difficulty relating to peers
____withdrawal/avoidance
____appears to have inner racing
____limited organization skills
____low motivation
____limited sense of aliveness
____lack of desire to grow up
____low frustration tolerance
____depressed
____rejects responsibility
____disruptive
____difficulty with time concepts

DEVELOPMENTAL HISTORY

____mother's stressful pregnancy
____delay in motor development
____recurring ear infections
____allergies
____physical disability
____difficult birth
____delay in language development
____recurring congestion
____health problems

AIT - SOUND SENSITIVITY QUESTIONNAIRE

PARTICIPANT NAME:_____DOB:_____AGE:_____
(Please Print)

DIAGNOSIS:_____

Please answer the following:

As they pertain to **YOU**, if **YOU** are the participant,..**OR**...

to **YOUR CHILD**, if you are the participant's **PARENT/GUARDIAN**.

1. Is the participant presently frightened or bothered by certain sounds?

2. If the participant is not currently bothered by certain sounds, was this a past problem?

3. If the participant outgrew the fear of loud sounds, at what age did this occur?_____

4. How often has the participant had ear infections?

    ____never _____several, over a few years and treated with medication
    ____once or twice _____constantly, with medication and tubes

5. Has the participant been diagnosed as having a permanent hearing loss?

IF THE ANSWERS TO QUESTIONS 1 AND 2 ARE 'NO' STOP HERE !!!!

IF NOT PLEASE CONTINUE

6. Check the following noises that had or still repeatedly bother the participant.
(Use the letter "C", for any Current problem, or the letter "P" for any Past problem)

____airplane overhead ____motorcycle
____loud auto muffler ____garbage truck
____fire engine siren ____hammering a nail
____power saw ____electric drill
____telephone ringing ____firecracker
____squeaking toys ____dog barking
____lawn mower ____playground noise
____loud music ____vacuum cleaner
____food blender ____train whistle
____TV at normal volume ____other (Please specify)

7. How does (or did) the participant react to the above noises?

____covers ears ____cries ____says "it hurts my ears"
____says something like "I don't like it" ____cringes
____other (Please specify)_____

8. Was the participant or the parent/guardian counseled about what to do to help the problem with sounds?_____If so, what?._____

9. In general, the most important characteristics of sound that bother the participant are (Check all that apply)

____how loud the sound is ____a high pitched sound like a "squeaky wheel"
____a low pitched sound like an air conditioner ____a sudden sound
____other (Please specify)_____

IT - PHYSICIAN VERIFICATION FORM

_____
has been seen by me on
(Participant's Name)

_____for an examination of his/her
(Date)
auditory pathways. There was no blockage or obstruction of the passage of sound to the middle ear cavity and no middle ear anomalies were evidenced.

Physician's Name
(Please Print)

Signature

Date

يعتبر **تدريب التكامل السمعى Integration Training Auditory** من الاتجاهات الحديثة فى مجال تأهيل مرض التوحد Autism والنشاط الزائد
(ADHD) وصعوبات التعلم Learning - Disability، وتعتمد فكرة هذا التأهيل على نظرية تفسير الأعراض التى يعانى منها هؤلاء المرضى – من انطواء أو نشاط زائد أو نوبات هياج وغضب – على أنها نتيجة لخلل فى عملية التكامل الحسى والتى يستطيع الشخص من خلالها الاستفادة من المدخلات الحسية (سمعية – بصرية – لمس ...الخ).

أسباب هذا الخلل وعلاجه:

وهذا الخلل ينتج من وجود حساسية مفرطة لبعض المؤثرات السمعية أو البصرية أو الحسية. وقد توالت الأبحاث العلمية في السنوات العشرة الأخيرة بما يفيد أن علاج ظاهرة الحساسية المفرطة للأصوات يمكن أن يتم بنجاح عن طريق إخضاع الطفل لعدد عشرين جلسة تأهيلية لتدريبه علي سماع أصوات مصممة بطريقة معينة وذلك من خلال **جهاز تدريب التكامل السمعي** والذي يقوم بتنقية الأصوات المدخلة من بعض الترددات التي تسبب إثارة وألم للطفل المصاب.

نتائج هذا العلاج:

وقد تم التأكد من أن هذا التأهيل يؤدي إلى تحسن كبير في الحساسية المفرطة للأصوات أو المدخلات الحسية الأخرى هذا بالإضافة إلى تغير أكيد وملحوظ في النمط السلوكي لهؤلاء الأطفال مع نمو في قدراتهم علي التواصل والتعلم وقد يؤدي إلى تطور في القدرات السمعية والنمو اللغوي والمهارات الأخرى مثل الرسم واللعب التلقائي والاستجابة للتعليمات البسيطة والمركبة.

أسباب التأثير الإيجابى للعلاج:

وقد تم تفسير التغيير السلوكي وتطور قدرات التواصل والتعلم علي أنها نتيجة لتغيير في مستويات الموصلات العصبية مثل السيروتونين والابيويدز (Opioipds & Serotonin) ينتج من تأثير هذا التدريب وقد ثبتت هذه الحقائق من خلال الأبحاث.

معلومة هامة:

لا يعتبر هذا التأهيل علاجاً تاماً للتوحد ولكنه يعتبر عاملاً مساعداً هاماً ثبت نجاحه (من خلال متابعة أطفال مصريين تلقوا هذا التدريب بالخارج وأيضاً فى مصر بمركز السمع والاتزان Ear Care)، ويساعد بفاعلية في تقدم الطفل في برامج العلاج السلوكي والنفسي والتخاطبي.

أسباب اختلاف استجابة الأطفال للعلاج:

تعتمد درجة نجاح هذا التأهيل علي عوامل عدة منها: نوع وشدة المرض، التقييم السمعي الدقيق لتحديد مناطق الحساسية المفرطة في المجال السمعي، والخبرة العملية والعلمية لمن يقوم بضبط جهاز التدريب والبرامج التأهيلية التي يشترك فيها الطفل بعد العلاج.

Auditory Integration Training: Frequently Asked Questions About Berard AIT

1. **DOES BERARD AIT REALLY WORK?**

   Yes. AIT is an educational intervention that efficiently retrains a disorganized auditory system. Auditory Integration Training is a scientific method of retraining the ear to listen and to process sounds in a more normal manner, without distortions and delays. While no guarantees can be made, AIT is documented to have profound positive effects on many different types of individuals.

2. **IS THE BERARD METHOD OF AIT A MEDICAL INTERVENTION?**

   No. It is considered to be an educational intervention.

3. **ARE THERE ANY SCIENTIFIC STUDIES ON BERARD AIT?**

   Absolutely! The Berard Auditory Integration Training method has over 30 years of scientific research and **28 published clinical studies** documenting it's effectiveness as an educational intervention.

4. **WHAT AMOUNT OF TIME IS REQUIRED?**

   Participants listen to specific music using high quality headphones for a **total of ten (10) hours for a total 20 sessions** over a 10 or 12 consecutive day period, for **30 minutes per day**, **twice a day** with a minimum of 3 hours in between listening sessions.

5. **WHAT IS THE TYPICAL COST FOR THE 20 SESSIONS?**

   Cost of **AIT Sessions** varies in the USA and Internationally, depending on the geographic location and AIT Practitioner used. Any audiological tests required are typically at an additional fee.

6. **WHAT IS THE MINIMUM AGE TO PARTICIPATE?**

   Berard AIT may be done for any Participant **age 3 and up** who can cooperate with the Berard method and demonstrates the need.

7. **IS A PARTICIPANT CLOSELY MONITORED?**

   Yes! The Berard AIT Practitioners go through an extensive certification and training. Their certification requires that they follow the Berard protocol. Berard AIT is always done under the supervision of a professionally trained and properly certified AIT Practitioner.

8. **ARE THERE ANY AUDIO TESTS NEEDED?**

   Certain audio tests are administered if a Participant is old enough and/or can cooperate with auditory testing. Audio tests may be given prior to sessions and during sessions to provide information about a Participant's auditory pattern and are the basis for determining the use of filters, if any**.** The use of filters is NOT required for success with Berard AIT.

9. **IS SPECIAL MUSIC REQUIRED?**

   Yes. The Berard Auditory Integration Training protocol requires that a Participant listen to a selected type of modulated music on special device developed for Berard AIT.

10. **WHO INVENTED BERARD AIT?**

Dr. Guy Berard. of France developed Auditory Integration Training as a procedure to **efficiently retrain a disorganized auditory system**. He treated and reviewed cases for over 8,000 clients during his 40 year career. He is the author of the ground-breaking book ***"Hearing Equals Behavior"***. Through his years of research, Dr. Berard determined that when **auditory processing** is not working correctly, it prohibits the efficient processing of information. **Dr. Berard believed that hypersensitivity to sound, hearing distortions and delays in the auditory signals contribute to inefficient learning.**

11. **HOW DOES BERARD AIT ACTUALLY WORK?**

Berard AIT uses electronically modulated and/or filtered music to retrain the ear and auditory system to work properly. Current research confirms that Berard AIT retrains the acoustical reflex (stapedius) muscle of the inner ear. How we listen to and processed auditory information and sound affects our alertness, attention span, concentration, information processing, and the way we express ourselves, both verbally and in writing. When the listening process or the auditory system is not working properly or integrated, it can interfere with our entire system and our ability to function optimally.

12. **WHAT CAN CAUSE THE DAMAGE THAT REQUIRES SOMEONE TO NEED BERARD AIT?**

There are many situations that can result in damage to auditory processing, sound sensitivity, hyposensitive or hypersensitive hearing. or hearing distortions in people of all ages. Some of possible causes of sound sensitivity include such things as: birth trauma, repeat **ear infections** as an infant or young child, frequent use of antibiotics, vaccine damage, use of ototoxic medications, heavy metal toxicity, exposure to loud noises, head injury, traumatic brain injury, stroke and many other situations.

13. **ARE THERE ANY SUCCESS STORIES ABOUT BERARD AIT?**

Absolutely! Read the many **success stories** and **testimonials** written by parents of special needs children and also **adults** who completed the Berard method of AIT - with remarkable gains

14. **WHAT HAPPENS AFTER BERARD AIT?**

Once the cause of the auditory processing or hearing problems are corrected - such as **hearing distortions, hypersensitive hearing, hyposensitive hearing, sound sensitivity** - then other therapies and educational programs become more effective in producing changes that enable the individual to achieve a new level of success.

The Effects of AIT often include:

- Calmer overall behavior!
- Happier nature, more cheerful disposition
- Consistent demonstration of age appropriate behavior
- More appropriate voice volume for a given situation
- Improved academic performance
- Improved ability to focus and attend in a variety of situations
- Improved frequency and easier interactions with others
- Improved social skills
- Improved expressive language
- Improved language discrimination
- Improved language comprehension
- Improved ability to function in background noise
- Improved concentration ability
- Improved sensory processing
- Improved speech
- Improved handwriting
- Improved vocabulary
- Increased eye contact
- Increased affection, expression and interaction
- Increased physical comfort level
- Increased self-esteem
- Increased compliance and cooperation
- Increased independence
- Increased interest in verbalization and communication skills
- Reduced hyperactivity
- Reduced distractibility
- Reduced hyper-acute and/or painful hearing
- Reduced noise (or tinnitus) in the ear
- Reduced startle responses to loud noises
- Less irritability
- Less complaints of various sounds causing pain or discomfort
- Less impulsivity and restlessness
- Less lethargy

Alia for Early Intervention
For a brighter future!

SB14108

Ear Check Before Berard AIT & MHBOT

The Ear Check by a medical practitioner should be conducted within 5 days BEFORE starting Berard AIT. The tympanogram by an audiologist is required in that same time period.

- Some parents may opt to have an **Ear Check and/or the tympanogram** performed earlier than 1 week prior to Berard AIT in addition to what is done just before Berard AIT starts if there is concern about recurrent infections, fluid, wax, or ear drum/middle ear problem.
- **A child's Ear Health should be checked again by a medical practitioner just before the 11th session to assure that the ears are still at their best.**
- Parents and practitioners alike need to plan for the 10 day session and associated schedules and logistics. Parents often need some time to prepare children for Berard AIT.
- **Tests and checks are ideally scheduled a week prior to Berard AIT (or under a week - 7 days).**
- Parents with children who have ear health issues need to fulfill the minimum requirements and also use their best judgment for timing the ear checks and tests.
- **Hyper-Defensiveness:** When children react strongly to medical instruments used around their ears, obtaining good results with ear checks and tympanograms can be difficult or impossible. Physicians and audiologists may be asked to help parents and Berard AIT Practitioners with judgment calls about ear health and readiness for Berard AIT. The input by such specialists would be based upon children's known ear health and/or middle ear function history.
- **Please do NOT be overly concerned if you are the parent of a child who is ineligible to perform these tests because they are under the age of five OR because they may have difficulty participating in the audio tests. The tests may provide valuable information resulting in a tangible benchmark as to the effects of Berard AIT but not not essential to it's success.**
- Children who are not able to cooperate with the testing process at their first audiological appointment may be able to by their midpoint appointment due to the positive effects of Berard AIT.