

Play Therapy™

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Neuroscience and Play Therapy

*Working to Help Children
on the Autism Spectrum*

*Ethical and Legal Responsibilities
of the Play Therapist when*

Encountering Clients with Disabilities

A Remedy For ADHD:

Play That Emotionally Arouses and De-Arouses Children

Adapting an Intervention Model:

Play Therapy with a 4-Year Old Girl Impacted by Selective Mutism

Everything really is Bigger in Texas!

2008 Conference & Survey

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Mission: To promote the value of play, play therapy, and credentialed play therapists. To satisfy this mission, the Association for Play Therapy will advance the psychosocial development and mental health of all people by providing and supporting those programs, services, and related activities that promote the:

1. Understanding and valuing of play and play therapy.
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CLINICAL EDITOR: This article discusses the use of the DIR/Floortime Model typically used for work with children with Autism Spectrum Disorder. The author discusses a rationale for the adaption of this approach in play therapy with children with Selective Mutism. She presents a case to illustrate the benefits.

Adapting an Intervention Model: **Play Therapy with a 4-Year Old Girl Impacted by Selective Mutism**

"Selective Mutism is a psychiatric disorder that affects seven out of every 1,000 children making it almost twice as common as autism" (Brown, 2005, p.9). It is an extreme form of social anxiety disorder where "a child cannot speak in select settings, most typically at school, even though they can (usually) speak normally at home" (Cole, 2006, p 57).

Although environmental stresses play an important role in anxiety and other mood disorders, most children with Selective Mutism have a hereditary predisposition to anxiety disorders (Shipon-Blum, E., 2003, p. 2). Parents are often confronted with painful recollections of their own inhibited childhoods as they watch their child with Selective Mutism struggle in the social world. "Fifteen years ago, these children were known as elective mutes, and their silence was seen as willful and manipulative. The diagnosis was changed to Selective Mutism in the fourth edition of the American Psychiatric Association's Diagnostic Manual" (DSM-IV-TR, p.125). This new definition reflects a greater understanding that children suffering from Selective Mutism are not choosing to be silent. They are literally so anxious they have developed dysfunctional coping skills to combat anxiety that most often includes avoiding social interactions. "As a consequence of these dysfunctional coping skills, children with Selective Mutism are often misdiagnosed with a variety of disorders that range from the child being 'just shy' to autistic to oppositional and defiant to selectively mute" (Brown, 2005, p.1).

A mistaken diagnosis of Autism brought a four-year old girl with Selective Mutism to my attention. I am a developmental psychologist; I specialize in work with children impacted by regulatory and/or developmental delays such as Autism.

This child presented with such immobilizing social anxiety, that to the lesser-trained eye, her behavior could have been interpreted as Autistic. She made little to no eye contact with persons outside her family, appeared to have lost language since the age of two and had great difficulty making and keeping friendships.

The pediatrician initially told her parents she would grow out of her extreme social inhibition. The reassurance was well meaning but misguided. Children with Selective Mutism do not outgrow the disorder. Social anxiety becomes more defined as the child grows older, and the anxiety becomes more difficult to treat once symptoms have been in place for several years (Shipon-Blum,

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2003). When the child did not improve and began to exhibit extreme forms of social withdrawal, the pediatrician admitted to being stymied and suggested he may have overlooked the potential for a developmental delay. He subsequently referred the child to me.

Early intervention is the best option for progress when treating Selective Mutism. "Treatment can include a regiment of medicinal, behavioral, cognitive and/or developmental techniques" (Brown, p.9). My own interest in developmental psychology led me to a developmental/relational approach entitled DIR/Floortime model®. The 'DIR' stands for D (Developmental), I (Individual differences) and R (Relationship-based) components of the model (Greenspan & Wieder, 1999). While most closely identified as a treatment protocol for autistic children, DIR/Floortime, a play based social-pragmatic intervention, can be used to successfully treat children impacted by Selective Mutism by identifying the steps leading to relating, communicating and thinking (Greenspan & Wieder, 2006).

DIR/Floortime model provides a framework for understanding human development and learning. Floortime involves identifying a child's current developmental level. This includes time observing children and identifying their interests and often begins with an adult sitting on the floor of the playroom. In developmental terms, the adult follows the child's lead by assessing emotional investment in an activity and then helping the child stay engaged and regulated by expanding on that initial interest by adding creative play elements. This is accomplished spontaneously or by gathering information from events in the child's life, events that encourage extended periods of prolonged interaction. The DIR/Floortime model supports parents as their child's primary play partners and offers naturalistic play-based interactions that engage the child's affect. Parents are taught to synchronize their behaviors and emotionally attune themselves to their children's attention and activities to help children develop superior joint attention and language. Greenspan and Weider's 'affect diathesis hypothesis' asserts that affect drives meaningful development (Solomon et al., 2007). DIR/Floortime does not reference the end product of speech in some performance based presentation, rather the underlying developmental processes are explored and supported, so optimum interactive relationships and subsequent language production prevails (Greenspan & Weider, 1999).

This model focuses on specific developmental stages of children and the different ways children take in environmental messages. This approach aims at translating information into understandable messages between children and caretakers. Adults engage children at their level of emotional, social, intellectual, and language functioning, then tailor the approach to children's biological profiles. There is an emphasis on ways children take in information through their senses. The purpose is to build relationships. Clinicians instruct parents regarding the principles of play-based intervention and how to apply them to (a) their child's preferred way of relating, (b) their child's sensory motor preferences and deficits and (c) their child's current level of functional development. The parent is then taught to expand on a child's original area of interest by reflecting back and giving meaning to the child's actions. Reflection at the appropriate developmental level creates a 'no pressure' approach where the focus between caretaker and child is not about speech but rather the reciprocal relationship. Normal communication patterns eventually emerge as a consequence of these relational interactions. In addition, clinicians work with parenting partners to help them examine their own feelings (often marked by a sense of shame, guilt or helplessness) of having a child afflicted by Selective Mutism.



“...she picked up the doctor puppet figure and the toy doctor kit and began to put multiple band-aids over the mouth of the toy.”

The Case of Sara

In the following brief case presentation I discuss my clinical experiences with Sara, a four-year old girl, and her parents. My work includes a session following a traumatic experience at the dentist's office. By utilizing the methods associated with the DIR/Floortime model, spontaneous speech emerged. Although this child's inhibitions and presenting social withdrawal represents an extreme example of the disorder, her presentation of Selective Mutism symptoms should not be confused with those of Post Traumatic Stress Disorder (PTSD). PTSD is indicative of trauma reaction towards a specific incident(s) (DSM-IV-TR, p. 467) while in Sara's case, her reaction exemplifies the way in which children with Selective Mutism often overreact and shut down during typical social situations. The critical importance of creating a therapeutic alliance with the entire family is also examined, as a way to assure that unresolved issues of the parents do not impede their child's progress. During this session, Sara had been in treatment approximately two months; she had just begun to talk to me.

As soon as Sara entered into the playroom she immediately began taking puppets off the puppet tree and throwing them around the playroom. This presenting outburst gave me the

impression of dealing with a child much younger than Sara's chronological age. I applied the DIR/Floortime principle of "D", development, to assess the situation and immediately adjusted my language use to meet the child at this younger developmental level. Rather than stop the flow of activity, I followed the child's lead and simply reflected back to her the feelings that I was experiencing as the tumult unfolded. At this point in the exchange, the child momentarily stopped her actions and appeared to take in my words. With renewed frustration, she picked up the doctor puppet figure and the toy doctor kit and began to put multiple band-aids over the mouth of the toy.

Again I followed the lead of the child and began to expand reflectively on the play scene. I said, "I am very angry at your doctor. You put tape over my mouth and it really hurts". The child vigorously shook her head in agreement and for the first time in the session began to speak. She said, "He put tape on my mouth and it scared my mouth here", (indicating the side of her left cheek). I turned to the parents who were also participating in the therapeutic playroom and they informed me about their child's recent dental visit. Both parents continued the theme of their child's play and began to help her work out the trauma she had experienced; they became play figures in the drama. Sara's language flowed easily at this point as she was encouraged through the play to express feelings of anxiety, frustration and helplessness.

Later in the session I met with the parents and expressed the need for the intervention team to work together. This meant becoming informed of important experiences in the child's life prior to each session, so that the hour might reflect more accurately the experiences of the day. The parents admitted they had not thought previously to share the dental incident

because they did not want to acknowledge to themselves the gravity of their daughter's issues.

Although empirical evidence is lacking regarding this method of intervention for children suffering with Selective Mutism, clinically, I have found this model useful. The primary reason is the emphasis on the relational aspects of play that view the production of language as a byproduct of affect-driven interpersonal exchanges.

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