

Floor Time as a Play Therapy Intervention for Children Impacted by Selective Mutism

Written by Esther B. Hess, Ph.D., Clinical Psychologist
Senior Clinician for Stanley Greenspan, M.D.
Certified in DIR/Floor Time

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Selective Mutism is a psychiatric disorder that affects 7 out of every 1,000 children (making it almost twice as common as autism) yet; it is seldom dealt with within the confines of a psychotherapist's office. 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.

Selective Mutism is a disorder that impacts both the child and his or her entire family. Parents and siblings often describe feelings of helplessness and shame associated with this mysterious ailment. There is little understanding and subsequently little empathy for these children who often are frozen with fear as they try to confront specific social settings. If left unchecked, the fear can grow and take over the life of the impacted individual. Adolescence for those affected by Selected Mutism, is characteristically marked by social isolation and withdrawal from most classmates and peers.

It is important to understand that 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. 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. Children suffering from Selective Mutism are not choosing to be silent nor refusing to speak, nor are they being oppositional. 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. Another popular misconception was that selective mutism was a form of post-traumatic stress disorder and that the child had stopped talking in public due to some deep dark secret at home. It was not uncommon for instance, for families to have been accused of abuse because their child was not talking in school.

For the typical Selective Mute child, the longer the mutism persists, the more difficult it is to overcome. Due to the mishandling and misconceptions surrounding this anxiety disorder these children can suffer in silence for years without the proper diagnosis and intervention. As mentioned, left untreated these children's defenses can grow into social

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isolation, poor school performance, self-medication with drugs and alcohol, the inability to seek employment as an adult, and in extreme cases even suicide, (Shipon-Blum, 2003).

Pediatricians often tell parents not to worry; their children will outgrow the problem. That reassurance is well meaning but misguided. It is imperative for correct diagnosis and treatment to begin as early as possible for the child suffering with this disorder. Treatment can include behavioral, cognitive and developmental techniques that gradually expose a child to frightening situations, with a lot of positive reinforcement. **Floor Time is a developmental intervention created by Dr. Stanley Greenspan that encourages play between the impacted child and his/her parent, teaching the parent to utilize their child's level of interest and motivation to get involved in social interactions with them. Dr. Hess, one of Dr. Greenspan's Senior Clinicians on the west coast, emphasizes a 'no pressure' approach where the emphasis between parent and child is not about speech but rather the relationship that is developing between the impacted individual and their mom or dad. Normal communication patterns eventually emerge as a consequence of these relational interactions. As part of the treatment plan, Dr. Hess often asks parents to expose their children to a variety of extracurricular activities and play dates 'in real time' in an effort to desensitize them to social experiences. In addition, Dr. Hess works with both parents and individual family members to help them process their own feelings (often, as mentioned, marked by a sense of shame, guilt or helplessness) of having a child (or brother or sister) afflicted by Selective Mutism.**

Case Illustration: Sara, a 4 year old girl impacted by selective mutism entered into the play room and uncharacteristically began to take the puppets off of the puppet tree and throw them around the room in a rather chaotic random way. This clinician had no idea what was causing the unusual outburst, but rather than stop the flow of activity, she followed the child's lead and simply reflected back to her the feelings that she (the therapist) was feeling as the tumult unfolded, guessing that the child might also share the same experience. "Boy, I feel angry today, I feel so angry that I just want to throw everything around. And I don't care if I make a mess...I am not cleaning up". At this point in the exchange, the child momentarily stopped her actions, took in the clinician's words and with

renewed frustration, 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 the clinician followed the lead of the child and began to expand reflectively on the play scene. “I am very angry at you 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. “He put tape on my mouth and it cut my mouth here”, (indicating the side of her left cheek).

The clinician turned to the parents who were also participating in the therapeutic play and had them fill in the missing pieces of the story concerning their child’s recent visit to a dentist, which was perceived by their daughter as being extremely intrusive. Both parents, under the guidance of the interventionist,

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continued the theme of their child’s play and began to help her work out the trauma that she had experienced in the dentist office by becoming the various play figures in the drama. Sara’s language flowed easily at this point as she was encouraged through the play to express her feelings of anxiety, frustration and helplessness. With Dr. Hess’s assistance, the family was encouraged to help Sara find an alternate solution to the dental visit and provide the child with the control that she so badly needed.

Dr. Hess met later in the therapeutic hour with the parents by themselves and expressed the need for all members of the intervention team (parents, clinicians, educators, etc.) to work together as a unit by being informed of important experiences in a child’s life ahead of a session, so that the session might reflect more accurately the experiences of the day. To the parents’ credit, they admitted that they had not thought to share the dental incident with the therapist because they did not want to acknowledge to themselves the gravity of their daughter’s issues which would necessitate both the preparation for and reviewing after of what they had hoped would be a routine dental visit.

Selective Mutism is an extreme form of social phobia that impacts thousands of children world wide, but is only recently being addressed by the psychiatric play community. Floor Time is a developmental play method that harnesses a child’s interests or concerns as the start point for intervention. In addition, underlying neurological differences are acknowledged and supported within the context of the therapy so that the interactions and subsequent speech that emerges from the interactions can be sustained. It is an ideal tool for servicing children impacted by this disorder due to the emphasis on the relational aspects of play that view the production of language as a byproduct of animated interpersonal exchanges, rather than a means to an end. Extended family members are

routinely drawn into the activities to facilitate both therapeutic resolution for the child as well as deal with their own conflicted feelings associated with this often misunderstood and maligned anxiety disorder of childhood.

References

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