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Role of Play-based Intervention in Managing Selective Mutism in a Young Child: A Case Study

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ABSTRACT

The available literature on play-based intervention for young children with selective mutism is limited. This case report describes the use of play therapy for a 6-year-old girl with selective mutism. The therapist used a child-centred play approach to establish rapport and engage in defocused communication and gradually introduced more directive play as part of stimulus fading. The improved score on the Selective Mutism Questionnaire (SMQ) indicated an increased frequency of verbalisation in various social settings. This case study suggests that play-based intervention provided a safe and engaging environment for young children with selective mutism to facilitate habituation to verbalise in social situations. This case report provides insights into the benefits of incorporating play therapy for young children with selective mutism.

Keywords: selective mutism, play therapy, defocused communication, case report

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1 INTRODUCTION

Selective mutism is a relatively rare anxiety disorder that predominantly affects young children, with a prevalence ranging from 0.03% to 1.9% (APA, 2022). It is characterised by an inability to speak in specific social situations despite being able to communicate verbally in other settings. The age onset ranges between 2 to 5 years old, but typically, the symptoms become apparent when the child is enrolled in the school for the first time (Schwenck et al., 2022). For instance, the most common scenario is when a child speaks fluently at home but remains mute at school. Some children with selective mutism engage in nonverbal communication, while others exhibit restrictive gestures (Vogel et al., 2022).

The absence of speech at school can significantly affect a child's education, as verbal communication is crucial in the classroom setting. The inability to speak hinders teachers' ability to assess the child's language and academic skills, making it challenging to provide appropriate support and monitor progress (McDaniel, 2021). Additionally, the child may face difficulties expressing needs, including necessities like using the washroom or seeking assistance. This communication barrier can result in frustration, social isolation, and overall educational impairment for a child with selective mutism (McDaniel, 2021).

To receive a formal diagnosis based on the DSM-5-TR, the selective verbalisation must persist for more than one month. It cannot be attributed to language familiarity, communication disorders, autism spectrum disorders, or psychotic disorders (APA, 2022). However, selective mutism is now recognised as a heterogeneous condition with common associated features such as oppositional issues, developmental delay, and language problems (Muris & Ollendick, 2021). Selective mutism also often coexists with social anxiety, with 69% of cases fulfilling the criteria for comorbid social anxiety disorder (Driessen et al., 2020). These co-occurring issues further complicate the management of selective mutism (Muris & Ollendick, 2021).

Given the anxiety-driven nature of selective mutism, cognitive-behavioural therapy (CBT) has been the primary focus of study on management. This therapeutic approach involves various components, including psychoeducation, physiological training, behavioural training (e.g., shaping, gradual desensitisation, exposure), cognitive training, and parent training. However, a recent systematic review by Hipolito and colleagues (2023) has highlighted inconsistent results in outcome studies of systems or behavioural interventions, possibly due to the inconsistent use of measures or less robust research methods. Besides that, the application of CBT for young children may face challenges due to children’s level of cognitive development (Heyne, 2022).

Alternative interventions have been explored for selective mutism, including play therapy. Understanding the role of play in managing young children with selective mutism will be helpful, given that children with this condition are often anxious about speaking, and play naturally serves as a medium for self-expression in young children. Play therapy involves a trained therapist using play systematically based on a theoretical modality to establish an interpersonal process and facilitate children to resolve psychosocial difficulties (Cochran, 2022). In play therapy, therapists use various tools, including sand, clay, toys, art, and music. Play therapy can provide children a

safe physical and emotional space to release their defences. It offers an optimal environment for processing emotions and challenges (Cochran et al., 2022). There are two main approaches to play therapy: (i) nondirective play, relying on the belief that children can independently address their issues when provided with suitable conditions and the freedom to play with minimal instruction; (ii) directive play, involving more significant input and guidance from the therapist to reach therapy goals (Glover & Landreth, 2015).

Various theoretical frameworks could be utilised in play therapy, such as child-centred play therapy, psychodynamic play therapy, play-based CBT, and Adlerian play therapy (Bryd et al., 2020). To illustrate, Child-Centered Play Therapy (CCPT) is a non-directive therapeutic approach focusing on building a relationship between the therapist and child to unlock the child's inner capacities for creativity, self-healing, and constructive expression during play, rooted in the principles of Rogers's nondirective therapy (Glover & Landreth, 2015). During free play, children can decide what and how they want to engage in the play process. In comparison, Psychodynamic play therapy seeks to assist children in expressing disruptive negative emotions through symbolic play and the interpretation of the underlying meanings of their expressions (Halfon et al., 2021). Previous case studies have explored the effectiveness of psychodynamic play therapy (Fernandez & Sugay, 2016), multimodal treatment involving behavioural techniques and play therapy with family involvement (Powell & Dalley, 1995), cognitive-behavioural play therapy with parental involvement (Wonders, 2020), and sand play therapy (Sim, 2012). Studies also found that effective treatment includes aspects of defocused communication technique, where the attention is shifted away from the child, such as having the therapist sit beside the child instead of facing them (Schwenck et al., 2022).

The available literature on play therapy for selective mutism is limited (Kearney & Rede, 2021). Hence, the present case study describes the use of play-based intervention for a 6-year-old girl with selective mutism in a hospital setting in Malaysia. This case study also contributes to the literature on the therapeutic role of play therapy and provides insights into its potential benefits as a treatment approach for selective mutism.

2 CASE STUDY

2.1 Background History

S, a 6-year-old Malay girl, was referred by his parents to the Psychology clinic for the management of selective mutism and behavioural issues. Her parents noticed her struggles when she was four years old, as she only spoke with immediate family members at home in the absence of others. Alongside selective mutism, S exhibited a fear of crowds and social events. At home, she also displayed behavioural problems, often throwing tantrums when her unreasonable demands were not fulfilled. Due to fatigue, her parents usually gave in to these demands, such as buying toys every time they went out.

S is the second child in a family, with her father working and her mother being a homemaker. Her 9-year-old elder brother is described as mild-mannered and has been bullied by S (e.g., S did not allow her brother to sit on a specific chair or touch her toys at home).

S was born with a low birth weight of 2.7kg and remained underweight. She reached speech and walking milestones on time. She predominantly preferred communicating in English and showed average learning ability when his parents coached her at home. She did not display rigidity in routines. She enjoyed make-believe play and played with her brother and other children in the playground. She was described as a fussy eater with a dislike for vegetables.

At the age of 4, S began refusing to attend preschool due to separation anxiety, and shortly after that, the COVID-19 pandemic lockdown occurred, and she did not attend school. When she attended kindergarten at six years old, she did not talk to her teachers or peers. She was capable of performing tasks when the teacher sat beside her. After six months of attending school, she stopped going as she often refused to sit down or eat. She would stand at the corner of the classroom while others were having lessons. S expressed to her mother that she dislikes the loud environment and the use of the Malay language at school.

2.2 Ethics

Parental written consent has been obtained for S to be involved in this case study. A pseudonym was given to ensure the anonymity of the case. Ethical review exemption was obtained from the UiTM (Universiti Teknologi MARA) research ethics committee in accordance with the ICH Good Clinical Practice Guidelines, Malaysian Good Clinical Practice Guidelines, and the Declaration of Helsinki.

2.3 Pre- and Post-Intervention Assessment

The Selective Mutism Questionnaire (SMQ) was used to monitor S's treatment progress. Her mother completed the SMQ during the first and tenth therapy sessions. The questionnaire consists of 17 items that measure the frequency of the child's speech in various settings, ranging from 0 (Never) to 3 (Always) (Bergman et al., 2019). S's score improved from 9 during the first session to 18 during the tenth session, indicating an increased frequency of verbalisation in various social settings.

The Wechsler Abbreviated Scale of Intelligence (WASI; Wechsler, 1999) was used to assess S's intelligence and assist in educational placement planning as she stopped attending school. The WASI comprises four subtests, including assessments of vocabulary, reasoning with similarities, block design, and matrix reasoning. S underwent the evaluation during the tenth session, where she was deemed ready to go through the test that involved verbal components with an unfamiliar evaluator. Her full-scale IQ was measured at 92, indicating Average intelligence. She performed better than 30% of children in her age group. Her Verbal IQ was 88, which fell within the Low Average range, performing better than 21% of children in her age group. Her performance IQ was 97, which is within the average range, and she performed better than 21% of children in her age group.

2.4 Treatment Summary

The first author, a Clinical Psychology doctoral trainee at the Psychology Clinic with prior training in play therapy and a 9-year background as a practising clinical psychologist, administered the therapy. The treatment plan for S comprised psychoeducation for parents on selective mutism, followed by a sequential implementation of child-centred and directive play approaches using behavioural principles of gradual exposure and defocused communication technique—the gradual progression aimed at fostering verbalisation and social interaction in S in the presence of unfamiliar individuals. A total of 11 sessions were conducted. Each session lasts an hour and usually has a two-week gap between sessions. The sessions were conducted in English in line with S's language preference. Given her young age, her parents were actively engaged during the treatment.

During the intake session, S's parents were provided with psychoeducation on selective mutism and behavioural strategies. For example, they were taught not to give in to tantrums and to provide positive encouragement when observing desirable behaviours with family members. The parents were also educated on anxiety symptoms and informed of the treatment plan.

During the first session, a child-centred or indirect play approach was used in the presence of S's mother. This approach involves defocused communication, where the therapist shows genuine interest in the child's play and reflects on what the child was feeling, saying, and behaving during the play without direct questioning and communication. Initially, S was quiet, but gradually, she began whispering to her mother and eventually could talk with her mother using an average volume and fluency in English. There was no verbal or nonverbal interaction directed to the therapist.

During the second session, S's mother shared that S felt happy as she could talk to her mother in front of an unfamiliar person after the first session. S expressed liking the "lady" (referring to the therapist) and the peaceful and quiet environment in the room. The therapist continued using the child-centred play approach with S and her mother present in the room. S vocalised naturally while engaging in pretend play, read books aloud, and started to engage nonverbally with the therapist by passing toy food, although still avoiding eye contact.

During the third session, S was accompanied by her brother and mother to the session. The therapist used a child-centred play approach during the sibling play session. S was able to play with her brother and verbalised normally. She also responded directly to the therapist when asked if her mother could leave the room. S's mother provided an update, mentioning that S expressed happiness about being able to talk naturally during the last play session. The therapist encouraged S's mother to enrol her in a hobbies class with her brother to provide opportunities for peer interaction. S was noted to be anxious when asked to greet goodbye by her mother to the therapist at the end of the session and left the room, avoiding eye contact with the therapist.

During the fourth session, S attended with her mother and brother. The therapist used a directive play approach and engaged S, her mother, and her brother in a game of Bingo. S was able to verbalise in the usual manner during the game. After the game, S's mother and brother were asked to leave the room, and the therapist continued with a child-centred play session with S. During this time, S could engage with the therapist through spontaneous vocalisation and interactive play.

However, she displayed a fearful facial expression and froze when asked by her mother to say goodbye at the end of the session.

In the fifth session, the therapist individually engaged S in a Pictionary game. S was able to engage in spontaneous interaction, including telling jokes. The therapist then asked her to create stories based on the pictures drawn, and S could share imaginative and creative stories with a loud volume and expressive facial expressions. However, she continued to show restricted expression and frozen body gestures when she had to say goodbye.

During the sixth session, S attended with her mother. The therapist engaged her and her mother in a Bingo game before her mother left the room. Later, the therapist facilitated S to create a puppet show that she could show her mother. S could tell her story with expressive body language and elaborate verbal expression. Her mother reported that S could interact naturally with her relatives during a recent trip to her grandparent's house. In this session, S spontaneously used a "Frankenstein" hand toy to wave goodbye to the therapist during the play. She verbalised goodbye to the therapist with the toy before leaving.

During the seventh session, her mother updated the therapist that S had started attending an art class with her brother. Although willing to attend, she still relied on her brother to communicate with the teacher. The therapist provided psychoeducation to the mother on conducting exposure to facilitate S's habituation to various social settings. The therapist engaged in child-centred play with S individually and showed normal verbalisation. She was able to say goodbye aloud to the therapist at the end.

During the eighth session, S's mother reported that S had started talking to others during her art class. Her mother also noticed that she was more relaxed with her relatives. The therapist engaged S in a word guessing game, and she was able to verbalise normally and showed creativity in making up stories with the words. She also shared what happened in her art class and greeted me goodbye at the end of the session.

During the ninth session, S's mother updated the therapist that S had been playing with her cousins during the last two weekends in their hometown. She also mentioned that S had started being willing to speak some Malay at home. The therapist engaged S in a Scrabble board game and invited two interns to join the session. S continued playing the game and shared an elaborate story using the game's words in the interns' presence.

During the tenth session, S could engage in expressive make-believe play with the two interns present during the previous session. Her behaviour was cheerful, talkative, and confident. One of the intern therapists, a trainee undergoing a Master's in Clinical Psychology, also administered the WASI test during this session. S was able to verbalise during the test without any issues. The therapist informed her mother that S was ready for the termination of individual sessions. Her parents were invited for a parent consultation session before termination.

Both parents attended the parent consultation, where feedback was provided regarding S's progress in the sessions, such as her ability to vocalise normally, even in the presence of unfamiliar people. The therapist also highlighted S's strengths, particularly her creativity, and shared the results of

her intelligence test, which indicated an average cognitive ability. The parents agreed with the progress reported, mentioning that S has been able to communicate with a teacher in the art class, talk to peers at the playground, and talk to her cousin, who could speak English. They also expressed that they had learned how to better manage her behaviours at home, including not giving in to tantrums and using explanations. They planned to enrol S in a small-scale homeschooling program next month. The therapist explained the next phase of treatment, which involved S attending group occupational therapy to enhance her social skills further. The parents were pleased with their child's progress and agreed to the proposed treatment plan.

3 DISCUSSION AND CONCLUSION

This case report presents a comprehensive description of the use of play-based intervention in a hospital setting in Malaysia for a 6-year-old girl with selective mutism. The patient, S, demonstrated average intelligence and typical language development but faced difficulties speaking in school, unfamiliar environments, and unfamiliar individuals, which led to her discontinuing school attendance. Consistent with previous literature (Kearney & Rede, 2021; APA, 2022), S's selective mutism was observed to be associated with social anxiety and oppositional behaviours at home. Given her young age, a play therapy approach based on the person-centred and behavioural framework was selected as the primary intervention to address her selective mutism and temper tantrum issues. This approach diverged from the traditional structured cognitive-behavioural therapy (CBT) sessions, which typically involve skill training, cognitive restructuring, and homework assignments that may not effectively engage young children (Heyne, 2022). It is important to note that the play therapy utilised in this case study did not incorporate a psychodynamic unconscious perspective, and S's play was not interpreted symbolically.

During the initial rapport-building stage, a child-centred approach was adopted, allowing S to engage in free play, the most familiar mode of expression for young children, where she can decide what and how to play. Her play revolved around themes of mastery, nurturing, and creativity. The utilisation of an indirect and defocused communication approach helped reduce S's anxiety and pressure to respond verbally (Schwenck et al., 2022). In child-centred play therapy, the therapeutic relationship is pivotal in facilitating positive change (Landreth, 2012). The therapist allowed S to take the lead and encouraged her to experience a sense of autonomy and control during the play sessions. Consequently, despite being in an unfamiliar hospital setting, which can be discomforting for children, a strong rapport and a sense of safety were quickly established.

After rapport was established, more directive play interventions were introduced. Incorporating elements of CBT within play therapy has been suggested as beneficial for children with selective mutism (Muris & Ollendick, 2021). Play therapy was employed within a behavioural framework in this case study to engage S in systematic desensitisation to social situations. Stimulus fading techniques were implemented (Kovac & Furr, 2019), gradually reducing the presence of her mother in the room and introducing unfamiliar individuals as part of the therapeutic process until habituation occurred. Although S initially struggled to greet the therapist at the end of the session, due to the pressure to speak, she eventually overcame this challenge by using a toy hand to habituate with the behaviour. Significantly, her ability to vocalise was not limited to the therapy

sessions but extended beyond therapy, as she was able to communicate with her relatives, teacher, and peers.

Furthermore, the active engagement of S's family members was emphasised throughout the treatment process. Rudy and colleagues (2017) suggest that adapting exposure therapy for young children with anxiety disorders should involve active coaching for parents. During each session, at least 15 minutes were allocated to provide updates, psychoeducation, and coaching to S's parents on how to support her outside of therapy and manage behavioural issues. Meaningful discussions regarding her educational placement were also conducted to ensure that S's holistic development was addressed in ways other than the presenting issues. The therapy concluded with a parent consultation involving both parents to share feedback and discuss the next steps for S. Additionally, sibling play sessions were incorporated into the treatment to facilitate stimulus fading and enhance the relationship between S and her brother. By the end of the treatment, S's parents demonstrated effective management of her behaviours, and her relationship with her brother showed improvement.

Regarding clinical implications, therapists working with children with selective mutism can consider integrating play-based techniques into their interventions to enhance engagement and promote positive outcomes. This case study supports the need to adapt traditional structured CBT for young children with selective mutism by incorporating play therapy techniques and child-centred approaches and focusing on behavioural and parental training. This adaptation allows clinicians better to meet young children's developmental and emotional needs. While it is challenging to involve both parents in the session, collaborating with at least one of the parents enhances treatment outcomes and facilitates the generalisation of skills learned in therapy to the child's daily life. Therapists are also suggested to consider the broader context and individual needs of the child, involving other professionals (e.g., occupational therapist or speech therapist) as necessary to ensure a comprehensive and integrated approach to treatment.

In conclusion, "play is children's language" (Landreth, 2012). Play-based intervention, which capitalises on children's language, was crucial in managing selective mutism in this young patient. The findings of this case study provide preliminary support for the effectiveness of play-based intervention combined with a person-centred behavioural framework and active parental involvement in addressing selective mutism and associated behavioural issues. As it focuses on a single patient, there is a limitation to drawing broad conclusions. Nonetheless, it contributes to the limited literature available on the use of play therapy in managing selective mutism in young children, specifically in Malaysia. Future studies could focus on developing a standardised treatment protocol tailored to young children with selective mutism. Randomised controlled trials would enable rigorous evaluation of the efficacy and effectiveness of such interventions. This would contribute to evidence-based practice and provide valuable insights into optimising treatment outcomes for children with selective mutism.

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