



This author provides an overview of the unique play deficits seen in children with Autism Spectrum Disorders, while offering a summary of best practice guidelines and useful intervention models. A list of recommended readings offers professionals a way to deepen their knowledge in this area. *Clinical Editor Paris Goodyear-Brown, LCSW, RPT-S.*

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Play-Based Intervention with Autism Spectrum Disorders (ASD)

By Esther B. Hess, Ph.D., RPT-S

The Autism Spectrum Disorders (ASDs) include several neurological disorder that affects behavior, the ability to communicate, interact and play in socially appropriate ways. Marked quantitative and qualitative differences exist in the play of children with autism spectrum disorders. A recent study from the Centers for Disease Control and Prevention estimates that 1 of every 150 children born in the United States is on the autism spectrum scale. The advocacies of early intervention programs have evolved as ameliorative in nature, to support the upsurge of children with special needs. Whether the increase is due to legislative support or advancement in detection methods, the proliferation of intervention programs has fueled evaluative research (Ramey & Ramey, 2004). To improve functioning for many of these children, coordinated and integrated services are required (Reddy & Savin, 2000).

Overall, toy play of children with autism spectrum disorders is more repetitive and less flexible and elaborate than neuro-typically developing peers, consequently they experience difficulty in playing with other children (Williams, Reddy and Costall, 2001). In addition, play skills do not progress in predictable developmental patterns (i.e., moving from exploratory to relational to functional to symbolic play). Exploratory play continues to dominate past the time at which typically developing children incorporate more sophisticated play strategies (Jarrod, 2003). Additionally, a child with autism spends less time than their typically developing peers in functional or symbolic pretend play (Kasari, Freeman & Paparella, 2006). However, summary findings with regards to the play patterns of children with autism point to the social challenges of this disorder particularly in the areas of communication and social cues that ultimately interferes with the capacity to play, having nothing to do with the specific desire of a child with developmental delays to play or interact with others (Thomas & Smith, 2004).

Recognizing these neurological limitations to traditional play, clinicians incorporating best practice strategies, use a variety of play-based interventions including client-centered/developmental models such as in DIR/Floor Time and Relationship Development Intervention (RDI), school-based interventions such as the Denver model, family work (including filial therapy and Theraplay) and cognitive-behavioral techniques as in ABA/Discrete Trial, to encourage developmentally sensitive and specific motivational tools to encourage play (Gutstein, Burgess & Montfort, 2007: Kok, Kong & Bernard-Opitz, 2002: Lantz 2001: Myrow, 2000: Rennie & Landreth, 2000: Weider & Greenspan, 2005). Children impacted by autism benefit from early intervention programs that are characterized by high intensity and individualized services. While Behavioral and Developmental models differ in their theoretical foundations; intervention

philosophies, methodologies, and meta-analysis repeatedly demonstrate that effective models follow several common universal best-practices. Programs should focus on a child's ability to attend to relevant aspects of his/her environment; develop verbal and motor imitation skills; develop language comprehension and functional communication; learn appropriate toy play skills; and develop social interaction with non-disabled peers (LeBlac & Ritchie, 1999; Ray, Bratton Rhine, & Jones, 2001; Whitaker, 2004).

Current best-practices standards for children with autism include an emphasis on the earliest possible screening and diagnosis to determine eligibility for services. Services should include parent involvement, incorporate activities and routines that are flexible yet predictable and be provided in multiple settings and utilize a combination of extrinsic and intrinsic motivators. Emphasis needs also to be placed on the duration of therapy with studies indicating that treatment outcomes appear to improve with a sustained treatment regiment (Elder, 2002; Solomon, Necheles, Ferch & Bruckman, 2007; Williams, 2003).

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Recommended Reading

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