

Selective Mutism: Why Won't They Talk?!

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- I. Background Information
 - A. Evolution of Disorder Definition
 - 1. "Aphasia Voluntaria" - Kussmaul, 1877
 - 2. "Elective Mutism" - Mortiz, 1934
 - 3. "Selective Mutism"- DSM-IV, 1994
 - B. Diagnostic Criteria For Selective Mutism (DSM-IV-TR, 2000)
 - 1. Consistent failure to speak in specific social situations (in which there is an expectation for speaking, e.g..., at school) despite speaking in other situations.
 - 2. The disturbance interferes with educational or occupational achievement or with social communication.
 - 3. The duration of the disturbance is at least 1 month (not limited to the first month of school).
 - 4. The failure to speak is not due to a lack of knowledge of, or comfort with , the spoken language required in the social situation.
 - 5. The disturbance is not better accounted for by a communication disorder (e.g..., stuttering) and does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder.
 - C. Facts of Interest
 - 1. Prevalence Figures: 7 per 1,000 or 1 in 143 in U.S.; occurs in 2% of early elementary age school children (Bergman, et al.,2002)
 - 2. Gender ratio: 1.9 female/ 1 male
 - 3. Onset age: 3-5 years
 - 4. Referral age/Diagnosis: 6-7 years
 - 5. Occurs across ethnic groups
 - 6. Responsive to early intervention
 - 7. Normal to high IQ
 - D. Mutism
 - 1. Organic
 - 2. Functional: Transient & Persistent
 - a. Symbiotic
 - b. Reactive
 - c. Passive Aggressive
 - d. Speech Phobic
 - E. Etiology- Possible Cause
 - 1. Some evidence of genetic link
Family history of social phobia, avoidant personality disorder (Chavira et al., 2007)
 - 2. Genetic predisposition to anxiety
One parent usually had extreme shyness or anxiety
 - 3. Theory- amygdala has decreased threshold of excitability (Fernald & Eastman, 2009)
 - a. Misinterpret social signals and overreact
 - b. Perceive mundane as threatening

- c. Primitive protective mechanism when feel threatened
 - 4. No evidence of abuse, neglect, trauma as cause
- F. Behavioral Characteristics
 - 1. Social Withdrawal / Isolation
 - 2. Excessive Shyness
 - 3. Oppositional
 - 4. Perfectionistic
 - 5. Speech Language Deficits
 - 6. Body Rigidity
 - 7. Flat Affect; minimal facial expression
 - 8. Avoid or averted eye contact
- G. Early Intervention Critical
 - 1. Prognosis improves significantly if intervention starts as soon as identified in young child
 - 2. Minimize chances of escalating emotional issues
 - 3. Prevent child from experiencing norm of not talking in school/public situations
 - 4. Difference by age of intervention

II. Assessment for Selective Mutism

- A. Often misdiagnosed or co-morbidity
 - 1. Social Anxiety or Avoidant Disorder
 - 2. Social phobia or other phobias
 - 3. Sensory dysfunction
 - 4. Enuresis
 - 5. Oppositional Defiant Disorder
 - 6. Obsessive Compulsive Disorder
 - 7. Attention Deficit-Hyperactivity Disorder
- B. Assessment Strategies
 - 1. Parent Interview
 - a. Confused; Jekyll-Hyde personality
 - b. Verbal at home
 - c. Manipulative/controlling versus shy/inhibited
 - d. Video-tape from home setting when child in comfortable setting often enlightening
 - 2. Interaction with Child
 - a. Receptive measurements of language comprehension
 - b. Nonverbal interaction
 - c. Expressive expectations in hierarchy
 - 3. Assessment Tools / Ideas
 - a. Peabody Picture Vocabulary Test
 - 1) Nonverbal /receptive evaluation
 - 2) Highly correlated with IQ
 - b. Bracken Basic Concept Scale
 - 1) Nonverbal / receptive evaluation
 - 2) School readiness categories
 - 3) Correlates with IQ
 - c. Selective Mutism Questionnaire
 - 1) Situations for parent and teachers to rate
 - 2) Part of Social Skills Rating System (Pearson Assessments)

- C. Speech-Language Issues
 - 1. Developmental language problems -Range of reported figures, from 40% -68%
 - 2. Evaluate Communication Areas
 - a. Receptive Comprehension
 - b. Receptive Processing
 - c. Expressive Language
 - 1) Phonology
 - 2) Verbal Organization
 - d. Pragmatics
 - e. Communicative Confidence
 - 3. Communicative Hypersensitivity/Anxiety

III. Collaboration and Consultation -Survey Research Study on SM (Toland, 1998)

- A. Survey of SLPs & Psychologists working in IL schools
 - 1. Lack of clarity regarding professional(s) responsible for assessment and treatment
 - 2. Most research studies on topic in psychology/psychiatry
 - 3. SLP among first professionals to encounter child w/SM
 - 4. Survey evaluated degree disorder being seen & treatment
 - 5. Assessed if significant differences between SLP & Psych re: SM
- B. Procedures for Survey Research
 - 1. 13 item questionnaire refined in pilot study
 - a. Multiple choice questions
 - b. Likert-type rating scales
 - c. Characteristics checklist
 - 2. 250 school based ISHA SLPs & 250 ISPA Psychs
 - 3. Survey Return
 - a. 246 returned surveys in total (49%);19 unusable
 - b. 121 from School Psychologists -return of 48%
 - c. 106 from SLP's - return rate of 42%
- C. Pearson Correlation Results
 - 1. Moderate correlation ($r > .40$) found between:
 - number of clients and comfort treating
 - number of clients and comfort diagnosing
 - 2. Weak correlation ($r > .30$) found between:
 - years of experience and comfort treating (School Psychologists only)
 - years of experience and comfort diagnosing (School Psychologists only)
 - 3. No correlation regarding formal training
 - less than 10% of total sample had any training
- D. Combination Approach
 - 1. School Psychologists - 15 different types, ranging from 2-5 different approaches.
 - 2. 36% felt combination approach should consist of behavioral and speech-language therapy.
 - 3. Speech-language pathologists also indicated 15 different combinations.
 - 4. 35% choose a combination of behavioral and speech-language therapy.
- E. Rank Order of Associated Characteristics

<u>School Psychologists</u>	<u>Speech-Language Pathologists</u>
Social withdrawal	Social withdrawal
Excessive shyness	Excessive shyness
Separation Anxiety disorder	Passive/aggressive behavior
Avoidant Disorder	Social phobia

- F. Rank Order – Observed Characteristics
 1. Social Withdrawal
 2. Excessive Shyness
 3. Passive/Aggressive Behavior
 4. Language Disorders
- G. Discussion
 1. Both groups seeing and treating SM
 2. Comfort levels for providing services relatively low for both groups.
 3. Despite lack of comfort, both groups indicated responsibility for providing services.
 4. School psych -SLP should be involved in assessment and intervention of SM
 5. SLP -school psychologists should be involved.
 6. Relationship between communication disorders & psychological problems in SM
- H. Summary of Survey Results
 1. Both groups view themselves as responsible.
 2. Very few have formal training.
 3. Respondents indicated low levels of comfort for services in SM.
 4. Majority would like to learn more about the disorder.

IV. Treatment Strategies

- A. General Treatment Strategies
 1. Multidisciplinary Team Approach
 2. Combination of behavioral, speech, and family therapy
 3. Need collaborative approach
 - a. School
 - b. Home /family
 4. Requires consistent reinforcement with natural consequences
- B. Treatment Types
 1. Behavioral Therapy – Desensitization
 2. Cognitive Behavioral Therapy
 3. Speech Therapy
 4. Medication
 5. Play therapy
 6. Parent Education
- C. Cognitive Behavioral Therapy
 1. Type of counseling approach
 2. Cognitive aspect is to explore the child's thoughts
 3. Talk about thoughts, emotion, options in a situation
 4. Behavior aspect is to change the child's actions; adjustment or change in the thought process leads to different behavioral reaction in a situation
- D. Speech Therapy Techniques
 1. Social Stories (Carol Gray)
 2. Picture Exchange Communication (Bondy & Frost)
 3. Floortime (Greenspan)
 4. Visual Supports
 5. Pragmatic Therapy
- E. Medication Options
 1. Anxiety issues tied to serotonin levels – chemical neurotransmitter in brain
 2. Sometimes necessary to consider anxiety-reducing medication – usually SSRI – serotonin reuptake inhibitor (e.g., Prozac, Zoloft, Paxil)
 3. Carefully monitor positive and negative effects of medicine

4. Goal is short term – not more than 2 months
 5. Not routine or endorsed at present for treatment of SM by FDA
- F. Play Therapy
1. Child and therapist engage in play activities
 2. Therapist observes child carefully and interprets subconscious communication and intentions in child's actions
 3. Psychoanalytical approach to treatment
- G. Parent Education
1. Parents often confused or in denial; different than child they experience at home
 2. Explore dynamics in environment at home
 - a. Don't want parent reinforcing the selective mutism
 - b. Don't want unmonitored pressure applied to child
 3. Provide support, encouragement, education for parents to assist in overcoming SM
- H. Global Guidelines to Treatment
1. Primary goal is reduction in anxiety
 2. Secondary is to build confidence in assuming communicative responsibility
 3. Work through stages from nonverbal to verbal with consistent reinforcement
 4. Carefully monitor communication expectations
 5. Use creative, fun therapy activities that promote engagement and minimize stress
 6. Gradually increase communication demands
 7. Carry-over intervention in various sites
- V. Behavioral Desensitization Treatment Approach
- A. Communication Goals
1. Desensitize to Communicative Pressure
 2. Transfer Communicative Responsibility
 3. Desensitization Hierarchy
 - a. Nonverbal
 - b. Ghost / Whisper
 - c. Motor / Voice
 - d. Carry-Over
- B. Nonverbal Desensitization
1. Non-academic tasks
 2. Highly motivating / interesting / enjoyable
 3. Natural or positive reinforcement for participating
 4. Non-participation is a choice; don't pressure
 5. Don't over-react to participation or non-participation
 6. Example tasks
 - a. Sorting by color, design,
 - b. Paint with water / coloring
 - c. Lotto / Bingo
 - d. Card Games (War) ; Board Games (Candy Land)
- C. Ghost Whisper
1. Can make ghost or transfer object
 2. Look at object, not at child's mouth
 3. Activities with one word simple response
 - a. Identifying numbers, letters, colors, shapes
 - b. Building with legos – request item
 - c. Object identification
 - d. Wheel-of-Fortune / Hangman

- D. Motor / Voice
 - 1. Car analogy
 - 2. Vowel prolongations
 - 3. Environmental sounds
 - 4. Activities with single word or carrier phrase
 - 5. Monitor carefully gradual increase in length and type of response
- E. Carry-Over Activities
 - 1. Craft activities
 - 2. Cooking – share with others
 - 3. Board and Card Games – Go Fish
 - 4. Invite peers / teachers to join session (their choice)
 - 5. Generalize across settings and people
- F. General Intervention Comments
 - 1. Stabilization/Carry-over is throughout the program. Once accomplish step in therapy, work to stabilize in external environment.
 - 2. Never proceed to next step until child has desensitized in therapy setting.
 - 3. Provide immediate, concrete reinforcement.
 - 4. Monitor pressure and keep communication fun & non-threatening.
 - 5. Parental / home involvement for consistency
- G. Indirect Goal: Teach child they have more control over their environment through verbal interaction.

VI. Summary Comments & Questions

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www.asha.org/slp/clinical/SelectiveMutism

www.selectivemutism.org