SELECTIVE MUTISM

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PRESENTATION OUTLINE

- Background Information on Selective Mutism (SM)
- Diagnostic Criteria
- Professionals Involved
- Evaluation
- Treatment

DEFINITION

"Selective mutism (SM) is a disorder characterized by a consistent failure to speak in specific settings (e.g., school, social situations) despite speaking normally in others (e.g., at home). SM is a relatively rare but serious condition that causes significant social and academic impairment if left untreated."

(ORBECK, BEATE, ET AL, 2016)

RED FLAGS

- Excessive shyness
- Social isolation and withdrawal
- Temper tantrums
- Disguising speech/voice
- Reduced eye contact
- Blank facial expression
- Lack of affect
- Staring
- Difficulty responding verbally and/or nonverbally
- Slow to respond

AGE OF ONSET

- Typically between 2-5 years old
- Often recognized when child first enters an educational setting in which speech is expected, language demands are higher, and less familiar individuals are present

ETIOLOGY

- No single cause.
- The following factors may coexist and play a role in selective mutism:
  - Genetic: Hereditary or genetic component with a significant overlap between selective mutism and social anxiety disorder (Black & Uhde, 1995; Cohan et al., 2006; Viana et al., 2009).
  - Neurodevelopmental: Associated anxiety disorders, such as social phobia, separation anxiety, and obsessive compulsive disorder (Beidel & Turner, 2007; Black & Uhde, 1995; Manassis et al., 2003).
  - Familial/Environmental: Familial links coupled with environmental factors, such as reduced opportunities for social contact, observing anxious behaviors, or reinforcing avoidance behaviors (Viana et al., 2009).
  - Temperament: Shy or timid temperament (APA, 2013; Steinhausen & Juzi, 1996).

RESOURCES FROM ("SELECTIVE MUTISM", 2019)

INCIDENCE & PREVALENCE

- Prevalence: estimates range 0.47% to 0.76%
- Estimate more females than males (ratio of 1.5–2.5:1)
- Affects approximately 1% of children being seen in behavioral health settings
- *Be careful! Higher prevalence rates in immigrant and language-minority populations due to diagnosing due to "silent period" common in second language learners*

RESOURCES FROM ("SELECTIVE MUTISM", 2019)

DIAGNOSTIC CRITERIA

SM categorized as Anxiety Disorder in DSM-5. According to DSM-5 (DSM-5; APA, 2013, p. 195):

- The child shows 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.
- The disturbance interferes with educational or occupational achievement or with social communication.
- The duration of the disturbance is at least 1 month (not limited to the first month of school).
- The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
- The disturbance is not better explained by a communication disorder (e.g., child-onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder.

RESOURCES FROM ("SELECTIVE MUTISM", 2019)

HISTORY OF DIAGNOSIS

1877	1934	1994	2013
Neurologist	Child psychiatrist	DSM-IV:	DSM-5:
Adolph Kussmaul:	Moritz Tramer:	*Selective mutism* classified among disorders first diagnosed in infancy, childhood, or adolescence	*Selective mutism* classified as an anxiety disorder
Aphasia voluntaria	*Elective mutism*		

Elective → Selective

Classification as anxiety disorder

(ORBECK, BEATE, ET AL, 2016)

ICD-10 BILLING CODE

- F94.0
- Inclusion Terms:
  - Elective mutism
- Exclusion Terms:
  - Pervasive Developmental Disorders
  - Schizophrenia
  - Specific Developmental Disorders of Speech and Language
  - Transient Mutism as a part of separation anxiety in young children

INTERDISCIPLINARY TEAM

- Pediatrician
- Speech Language Pathologist
- Psychologist or Psychiatrist
- Behavior Analyst/Behavior Specialist
- Teacher
- School Social Worker or Guidance Counselor
- Family/Caregivers

- The SLP's role on the evaluation team is to…
  - (a) identify and explain child's communication skills
  - (b) describe communication skills impact on child's ability to participate across settings
  - (c) provide referrals to behavioral health professionals
  - (d) collaborate with team to optimize outcomes and support generalization of skills

RESOURCES FROM ("SELECTIVE MUTISM", 2019)
(JOHNSON & WINTGENS, 2001)

EVALUATION

Complete a comprehensive evaluation to the best of your abilities! Here are some special considerations…

EVALUATION: PREPARATION

- Try to find a space where there will be no interruptions and no one else using the room
- Gather information from caregivers and teachers prior to meeting with child. This helps avoid discussion of child in front of them, creating more anxiety.
- Get information on child's interests to use within evaluation/therapy
- Explain parts of the process to caregivers/teachers
  - Observation of parent/caregiver and child first
  - Explain no expectations for child to speak during evaluation – helps reduce pressure (e.g.., "You need to talk to Ms. Sarah. This is what we came for. She needs to hear your voice!" → anxiety inducing)
  - Giving additional formulation time and not answering for them

RESOURCES FROM ("SELECTIVE MUTISM", 2019)
(JOHNSON & WINTGENS, 2001). (MIDDENDORF & BURINGRUD, 2009)

EVALUATION: STRATEGIES TO REDUCE ANXIETY

Avoid triggering the child's anxiety by using the following strategies:

- Minimize eye contact. Sitting side-by-side can help this.
- Use the terms voice or words rather than talk or speak
- Encourage non-verbal communication (draw, gesture, show, write, etc.)
- Create joint attention using preferred activities
- Provide behavioral descriptions of what the child is doing, rather than by asking direct questions (e.g., "I see that you're playing with the truck!" instead of "What are you doing?").
- Allow additional response time and periods of silence rather than talking for the child.
- Continue the conversation, even when the child does not respond verbally.
- Calmly acknowledge the child's responses in a neutral way.
- Use non-threatening tasks, such as a picture-pointing task

RESOURCES FROM ("SELECTIVE MUTISM", 2019)
(OERBECK, STEIN, WENTZEL-LARSEN, LANGSRUD, & KRISTENSEN, 2014) (SCHUM, 2006) (KOTRBA, 2015).

EVALUATION: OVERVIEW

- Parent/Guardian questionnaires and/or rating scales
  - The Selective Mutism Questionnaire (Bergman et al, 2008)
  - Other anxiety related questionnaires/rating scales – recommend leaving this to professionals with more expertise (e.g., psychologist, social worker)
- Interviews and record reviews
- Formal assessment as able (e.g., GFTA, PPVT, EVT, CELF-5, etc.)
- Non-standardized assessments
  - Language samples via audio and/or videotaping in familiar environments
  - Informal observation of speech-language skills (e.g., play-based, observing child/parent interaction)
  - WH-questions with picture options

CLINICAL PRESENTATION

- ARTICULATION: Typically WNL. "Presence of an articulation disorder may compound the anxiety of interacting with others (Anstendig, 1999). A comorbid phonological disorder was present in 42.6% of children in one study (Kristensen, 2000)."
- VOICE: Verbalization is often produced in a whisper/reduced vocal intensity. "Some children with selective mutism have reported that their voice "sounds funny" (Dow, Sonies, Scheib, Moss, & Leonard, 1995)"
- RECEPTIVE LANGUAGE: Typically WNL.
- EXPRESSIVE LANGUAGE: Weaknesses may be worsened by lack of experience. Reduction in length, detail, and linguistic complexity of narratives.
- COGNITION: Typically WNL. Challenging to evaluate true abilities.

RESOURCES FROM ("SELECTIVE MUTISM", 2019)

CLINICAL PRESENTATION

- PRAGMATICS: "Social immaturity is not uncommon because the child with selective mutism has fewer social interactions and may lack social awareness (Kotrba, 2015). Children with selective mutism can display decreased nonverbal and verbal indicators of social engagement, such as proxemics, facial expressions, gestures, eye contact, turn taking, participation in joint activity routines, and joint attention (Hungerford, Edwards, & Iantosca, 2003)."
- Context and person specific
- Better with friendly, funny, talkative people
- Easier to talk to other children
- Some can whisper to a friend
- Fear of mistakes and dislike attention

RESOURCES FROM ("SELECTIVE MUTISM", 2019)

DIFFERENTIAL DIAGNOSIS

- "The main differential symptom between SM [selective mutism] and other anxiety disorders, developmental disorders, or language-based disorders is that the **child with SM can talk in certain situations, but is not able to use that same quality/consistency/volume of speech in other situations due to anxiety**" (Kotrba, 2015, p. 27)
- Differentiating between silent period: "Bilingual children with true selective mutism present with **mutism in both languages**, in **several unfamiliar settings**, and for **significant periods of time**." (Toppelberg et al., 2005)
- "Children who do not speak as a result of trauma are **mute in all settings** (Manassis et al., 2003). If the **child spoke well prior to these events, then a diagnosis of selective mutism is not seemingly appropriate.** Instead, the child may require assistance in adjusting to the trauma or other life challenges "(Kearney, 2010),

RESOURCES FROM ("SELECTIVE MUTISM", 2019)

COMORBIDITY

"The largest study to date on children with SM (n=130) found that **social anxiety was the most prominent additional feature. Almost half also had borderline clinical scores for speech and language problems**—an important reminder as these problems may easily go unnoticed in these children. Another 45% showed borderline clinical scores on oppositional behavior. Only 12% had a "pure" social anxiety (Cohan et al, 2008). The authors suggest that the oppositionality shown by children with SM is often present only in situations that require verbal communication. That is, they **become oppositional and non-compliant when pressured to speak when they are anxious about doing so**."

(ORBECK, BEATE, ET AL, 2016)

TREATMENT

Unfortunately, research is limited.

Early intervention and building a relationship are the KEYS to providing effective treatment!

TREATMENT APPROACHES

Components/combinations of below strategies should be used to best suit the needs of each individual:

- Parent/Guardian/Teacher education and collaboration
- Behavioral Modification Interventions
- Augmented Self-Modeling
- Social-Pragmatic Approach
- Augmentative Alternative Communication (AAC)
- DIR Floortime
- Role Playing

Non-SLP Approaches: Cognitive Behavioral interventions & Pharmacological interventions

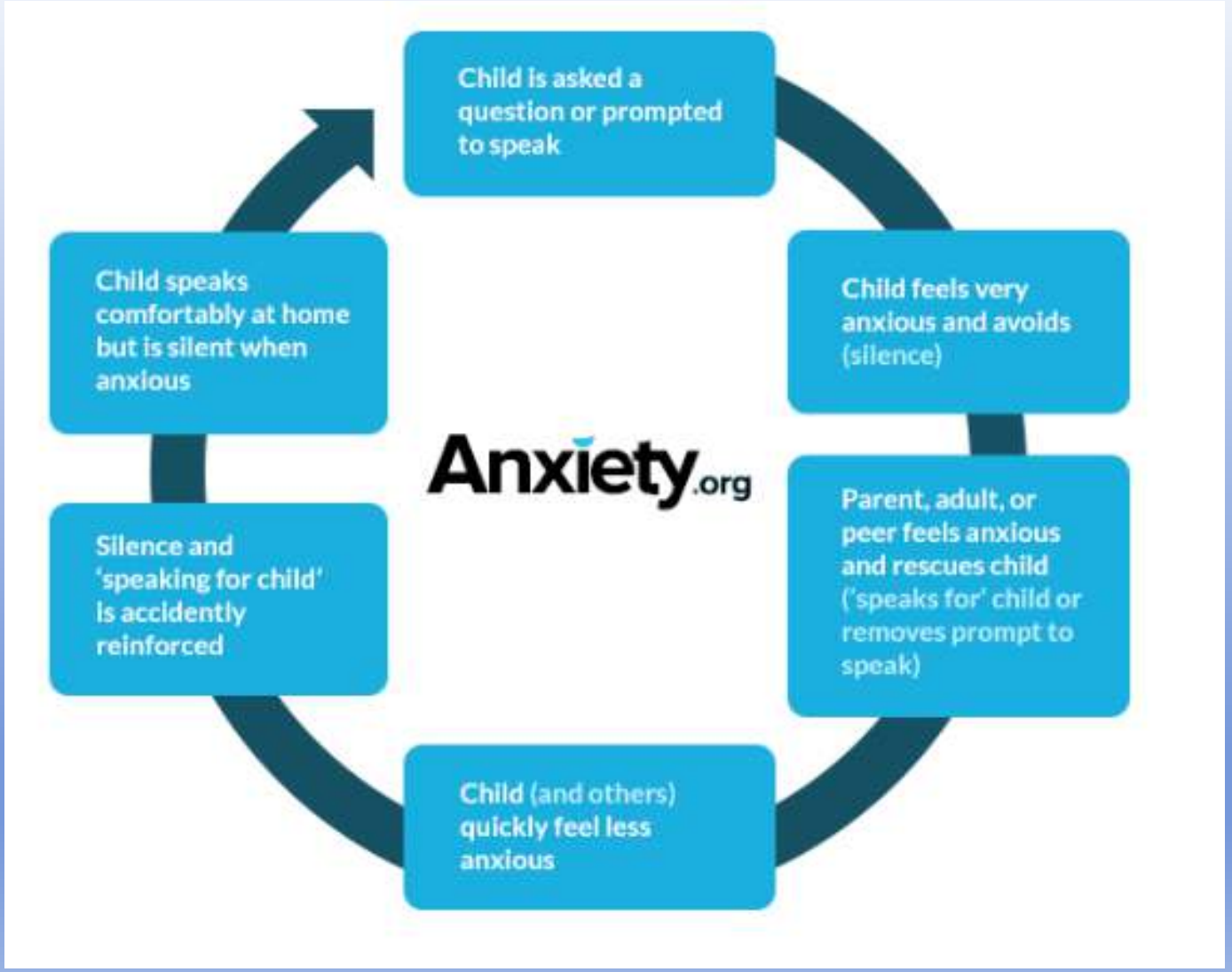
EDUCATION/COLLABORATION

Team education about SM and family training are extremely important

Provide strategies (several examples listed below from ASHA)

- Small groups with preferred peers
- Accept nonverbal methods of communication and work towards verbal
- Reinforce small improvements in a calm, non-attention getting way
- Reassure others that the child is still comprehending even if he/she is not talking
- Avoid speaking *for* the child, justifying child's silences, or pressuring the child to speak, all of which may reinforce mutism and anxious behaviors
- Support peer acceptance of nonverbal participation in classroom and recreational activities
- Find nonverbal jobs that the child with selective mutism can perform to build confidence
- Maintain the classroom routine, and try making the same request of the child at the same point in the schedule to decrease anxiety
- Try to set-up 1:1 discussions/check-ins with teacher and student to make a plan for best supports

RESOURCES FROM ("SELECTIVE MUTISM", 2019)



(SCHARFSTEIN, LINDSAY, ET AL, 2018).

BEHAVIORAL MODIFICATION INTERVENTIONS

- Despite research limitations, this has shown to be efficacious
- This approach sees SM as a behavior in response to anxiety
- Strategies incorporate practice and reinforcement of speaking in subtle, comfortable ways. Reinforcement could be verbal (e.g., praise), tangible (e.g., toy, fun activity), privileges (e.g., choosing game).

STIMULUS FADING

- Stimulus Fading is a process of slow integration and "desensitization" in 4 phases. The phases may be gradually applied to 1) varied environments 2) varied familiarity of relationships 3) varied group sizes and 4)increasing demands of spontaneous and immediacy of responses.

- Phase I: Familiar comfortable partner is sole communicator
- Phase II: New partner unobtrusively observes, no interaction
- Phase III: New partner communicates indirectly with client through comfortable partner
- Phase IV: Direct communication, including transfer of comfort to small groups (e.g. 2 peers) and increasing slowly to entire classroom.

SHAPING

Contingency management, positive reinforcement, and shaping. This includes (a) providing positive reinforcement contingent upon verbalization and (b) reinforcing attempts and approximations to communicate (i.e., shaping) until such attempts are shaped into verbalizations, with the goal of making verbalizing more rewarding than not responding. Shaping is commonly used in combination with contingency management and positive reinforcement.

Gestures/pictures/written → whispers →
vocalization (non-word & real words) → soft voice → full voice

RESOURCES FROM ("SELECTIVE MUTISM", 2019)

AUGMENTED SELF-MODELING

- Child watches a video/listens to audio of themselves using appropriate communication skills in a comfortable setting while in an uncomfortable/difficult setting
- Could also include editing a video to make it appear that the child is speaking comfortably within difficult settings (e.g., using video of child at home but editing to make it look as though they are in classroom)
- Used to facilitate self-confidence and generalization of appropriate communication to more anxiety-inducing settings
- Involves desensitization

"The three children involved in Kehle et al.'s (1998) study showed improvement in speech and at 7–9 month followups, all of the children were speaking freely and appropriately with peers. Self-modeling appears promising in the treatment of SM, but its use) in combination with a wide other behavioral strategies precludes conclusions regarding its unique efficacy"

(VIANA, ET AL, 2009)

SOCIAL PRAGMATIC APPROACH

- Emphasis on gradual increase in amount and complexity of social participation
- Uses shaping and reinforcement

- Gist of the process:

Part of join activities → nonverbal communication → hierarchy of production of sounds (e.g., nonspeech sounds to words) → hierarchy of language functions (e.g., answering non-personal/basic questions to answering personal questions) → ask non-personal questions to ask personal questions → participate in conversational turn taking

- Consider variables when changing communicative partners or contexdts:
  - WHO child is communicating with (familiar/unfamiliar)
  - WHERE child is communicating (therapy room, hallway)
  - PURPOSE of communication (join attention, requests)

EDUCATIONAL ELIGIBILITY

- Team decision for IEP or 504
- IEP under Other Health Impairment, Speech-Language Impairment, or Emotional Disturbance/Disability
- See drive for example of HS behavior plan for SM
- Accommodations:
  - Record verbal homework (e.g., class presentation)
  - Allow written and/or nonverbal communication
  - AAC
  - Preferential seating (specify – next to familiar friend; away from classroom door; near teacher; back of the room)
  - Small group and 1:1
  - Provide sentence starters, choices, yes/no questions
  - Allow additional formulation time
  - Respond in neutral tones to verbal participation
  - Minimize eye contact

QUESTIONS/COMMENTS/DISCUSSION STARTERS?

REFERNCES

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