Selective Mutism: Assessment and Intervention

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March 16, 2013
Goals

- Definition
- Professional Players
- Family dynamics
- What is the role of the SLP
- Evaluation strategies
- Intervention strategies
- Problem solve
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- Professional Players
- Family dynamics
- What is the role of the SLP
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- Intervention strategies
- Problem solve
What is Selective Mutism?

• Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)
  – ICD-9 code 313.23 (formerly elective mutism)

• Psychiatric diagnosis that applies to children who have a persistent failure to speak in school and social settings, despite being verbal in other settings
• May communicate freely in a setting where they feel more comfortable, such as at home.
• Often is not identified until child has attended preschool – school for at least one month
• Almost always given the additional diagnosis of anxiety
Prevalence of Selective Mutism

• 7.1 per 1,000 in U.S. (more recent information suggests is in 1 in 145)
• Occurs in up to 2% of early elementary school children
• Typically appears before age 5
• Diagnosis not usually made until age 7 -8

Family Genetic link

• Lifetime generalized social phobia
  – 37% (14 % controls)
• Avoidant personality disorder
  – 17% (4.7% controls)
• First degree family history
  – Social phobia -70%
  – Selective Mutism - 37%

Family Genetic Link

- Parents often report a familiar history
  - Shyness
  - Decreased speaking in social situations
  - Avoidance
  - Anxiety

What It’s Not (usually)

- Child is stubborn
- Child has been traumatized
- Child will just outgrow it
- Normal shyness
- Deliberate
- Child has speech and language disorder??
Characteristics

- Excessive shyness (and shyness/anxiety in family)
- Anxiety disorder (social phobia)
- Fear of social embarrassment
- Social isolation and withdrawal
- Compulsive traits
- Negativism
- Temper tantrums
- May disguise speech/voice
Characteristics

• Blank facial expression
• Lack of smiling
• Staring into space
  – “deer in the headlights”
• Reduced eye contact
• Frozen appearance
• Awkward stiff body language

• May have difficulty responding nonverbally
• May have difficulty initiating nonverbally
• May be slow to respond
• Excessive tendency to worry and have fears
Shy Characteristics

- Quiet
- Slow to warm-up
- May engage in eye contact, nod smile
- Mild-moderately uncomfortable in social situations
Shy or Selective Mutism

• Shy
  – In all situations
  – Consistent
  – Quiet, but can talk when they need to communicate

• Selective Mutism
  – In selective settings
  – Mute in at least one setting
    • Usually mute at school
    • Other settings are variable
  – Verbal in one or more settings
    • Usually at home
Related Conditions

- Obsessive compulsive tendencies
- Sensitive to touch, noise
- Questionable body awareness
- May be a candidate for occupational therapy
  - Sensory integration
- Anxiety behaviors
  - Chew fingers, clothing
Etiology

• Previous Philosophy: related to trauma, over-protective mother, over strict father
• Current Philosophy: social anxiety
• Genetic link?
  – Many children have a parent who is shy now, or in the past
Environment

• Environment and/or family socialization patterns may influence
  – Intensity of disorder
  – Maintenance of disorder

ASHA

- According to ASHA, selective mutism, should be treated in conjunction with a speech-language pathologist, pediatrician, and psychologist or psychiatrist

- ASHA.org
Players

• Professional
  – Primary care physician/pediatrician
  – Psychologist
  – Psychiatrist
  – Social Worker
  – School Counselor
  – Speech-Language Pathologist
  – Classroom Teacher
  – Occupational Therapist
• Parents, family
Physician

• May not have recognized the problem
  – Children usually do not “talk” at the doctor’s office
  – Parents may feel reluctant to discuss this
    • If they recognize this at all
• May have discussed with family with poor acceptance of the problem
Mental Health

• Psychologist
  – Counseling, family dynamics, psychotherapy
  – Systematic desentization
  – Direct work with schools
• Psychiatrist
  – Medication management with or psychotherapy
• Social Worker
  – Counseling and referrals for outside support
• School Counselor
  – Link between classroom teacher, family
Diagnosis

• Physician
• Mental Health
• Preferable
  – Decide together

Speech-Language Pathologist

• Assess child’s communication
• Treat functional communication
• Educate and counsel
  – Family
  – Teachers
  – Physicians
• Bring players together
Classroom Teacher

• Where the action, or inaction is
• Observation of child’s interactions and verbalizations
• Documenting changes in the natural environment
• Follow SLP’s lead and suggestions
Occupational Therapist

• Sensory-integration issues
  – Sensitive to loud noises
  – Fine motor issues
  – Reactive to touch
Family

• Level of understanding
  – Can be uneven among family members

• Ability to make changes in their responses to child

• Observation of child’s interactions and verbalizations outside of home/school

• Documenting changes in the natural environment outside of home/school
Is This a Communication Disorder?

• It is a psychiatric disorder that manifests itself in communication
  – ICD-9 code 313.23

• It functionally affects communication
  – Child has language skills, but unable to execute in certain situations

• The selective mutism is a control that reduces anxiety...makes child feel safe
Why is it Misunderstood?

• Child CAN talk
• Child reluctant to talk
  – Protective mechanism
• Child “appears” controlling
• Adults react with frustration and anger over a child “controlling” the situation
• Peers identify child as non-verbal to others
Family Dynamics

• Tendency may run in family
• Parent(s) has history or currently anxious in social settings
  – Excessively shy
• Parents may “rescue” child in speaking situation
• Parents may be over demanding of child’s (in)ability to speak
What is the Role of the SLP?

• Assess child’s communication
• Treat functional communication
• Educate and counsel
  – Family
  – Teachers
• Bring players together
Interview
• With one or both parents
• Child not involved

Assessment
• Formal
• Observation

Treatment
• Diagnostic therapy
• What strategies help
Questionnaire

• Gives family time to respond, and not be “on the spot”
• Create your own

• Rate behaviors on 0-3 scale:
  • 0 = never 1 = seldom 2 = often 3 = always

• Speaks to Most Peers at School
• Speaks to Selected Peers at School
• Answers Teacher


Interview

• Interview parent without child
  – 2 parents: one stays with child
  – 1 parent
    • Telephone interview
    • Child stays outside room
    • Child stays with staff member
Interview

• Put family at ease
  – Assess their level of comfort
• Describe the problem as they perceive it
• Pertinent developmental and medical history
• Information about where/when child does and does not talk

  Video
Interview - Home

• With immediate family
• With extended family
  – Family they see on a regular vs. occasional basis
• Neighbors in home
  – Adults vs. children
• Classmates
• Babysitter

Video
Interview - Neighborhood

- Adults
- Children
  - In own yard
  - In neighbor’s house
  - On “street”
Interview - School

- Peers
  - Most, selected
- When called on by teacher
- Groups
  - Circle time
  - Small clusters
- Participates non-verbally in class
- Parent present in school
Interview - School

• Communicates basic needs
  – Bathroom
    • Wets pants
  – Hurt or ill
Interview – Outside of School

• Restaurant
  – Orders own food
  – Responds to waitress/waiter
  – Talks to family when people nearby
    • Verbal when people removed

• Store
  – Responds to clerk
Interview – Outside of School

• Social
  – Scouts
  – Church
  – Play dates

• Signs of anxiety
  – Chew nails/hair
  – Belly ache

Video
Transition to Assessment

My expectation is no expectation
Transition to Assessment

• Parent(s) with child
  – Observe child via closed circuit system
    • Video if possible

• SLP enter room
  – Busy self outside of child’s activity
  – Observe any change in child’s communication
  – Join activity
    • Passive vs. active
Assessment

• Treatment starts with the assessment

• Assess receptive language skills
  – Is an ice breaker
    • Use picture pointing task
  – Non threatening

• Assess expressive language skills if child is verbal with SLP
Assessment

• Assess receptive language with picture pointing task

• Preschool
  – (Preschool Language Scale-5)
  – Non verbal parts of Clinical Evaluation of Language Fundamentals-P

• School Age
  – Non verbal parts of CELF-4
Assessment

• Expressive Language
• Proceed with verbal portions if you see some spontaneous speech in front of or to you.
  – Same language protocol as receptive
• Modify as appropriate
Assessment Precautions

• Assessment results may be misinterpreted or inaccurate due to:
  – Slow response time to directions/questions
  – Difficulty “initiating” verbal and/or nonverbal responses
  – Fail to answer due to “freezing” or loss of concentration
  – Look away from examiner as if they do not know the answer
Assessment Tips

• Minimize eye contact
• Talk “around” the child (Don’t use child’s name)
• Focus on something other than child (ex: toys, books)
• Have NO expectations for whether they speak or not
  • Let parents know your expectations of session
• PLAY with child without asking open ended questions
Assessment Tips

• Respond to child’s gestures as if he/she is speaking
• Use nonverbal tasks
• Use un-timed tasks
• Have a familiar person administer evaluation
• Allow frequent breaks of needed
Assessment Tips

• Allow supports
  – Non verbal supports
  – Parent close by
  – Physical comforts
  Video
Results

• Receptive Language
  – Usually normal or above normal

• Expressive Language
  – Usually normal if able to assess
  – Seemingly impaired pragmatic language skills outside of the home
  – Questionable pragmatic skills in the home

• Articulation: Usually normal

• May “disguise” voice or articulation”
Recent Study

- 25% with language deficits
- 23% with articulation and language deficits
- 12% articulation deficits
- 19% no deficits
- 66% overall with some expressive deficit

Alternate Methods of Assessment

• Selective Mutism Center:
  – Parents were trained to deliver test stimuli for vocabulary and narration
  – Monitored live from a separate room
  • Ear buds for prompts for SLP
  – Sessions were recorded for later transcription, scoring, and analysis by certified and licensed SLPs

Assessment Measures Used

- Clinical Evaluation of Language Fundamentals-CELF-4:
  - Observational Rating Scale
- Peabody Picture Vocabulary Test-4 (PPVT-4)
- Expressive Vocabulary Test-2 (EVT-2)
- Test of Narrative Language (TNL)
  - Comprehension & Oral Narration
  - Speech-language sample

Klein, R., Armstrong, L., Shipon-Blum, E., 2012
Assessment Tips

• Focus on functional information
• Standard scores
  – Report if accessible, but not the focus
• Focus on diagnostic therapy
Counseling

• Describe what you saw
• Offer information on selective mutism
• Discuss options for treatment
  – Speech and language therapy
  – Referral to mental health
  – Suggestions for school
    • IEP vs. 504
Levels of Communication

• Non Communicative
• Non verbal Communication
  – Gestures, head nods
• Transition to Verbal Communication
  – Use of sounds, AAC device
• Verbal Communication
  – Approximated speech – functional speech
Diagnostic Therapy

- Non verbal
  - Gestures
  - Pointing
  - Sound makers
  - Oral gestures

- Vocal
  - Grunts
  - Clicks
  - Animal sounds

- Verbal
  - Sounds/syllables
  - Words
  - Phrase
  - Sentences
  - Conversational
Varying Levels of Talking

- No communication
- Little speech
- Surprising spontaneous
- Consider letting parent do some of the assessment

Video
Subtle Language Difficulties?

• Shorter narrative skills than peers
• Parents may over estimate language skills

Recent Study

– Lower nonverbal and verbal social skills
– Lower phonological awareness
– Receptive Language Disorder (vocabulary)
– Expressive Language Disorder
– Speech Disorders (articulation & stuttering)

Evaluation Report

• Standard scores when appropriate
  – Valid?
  – Reliable?

• Report pragmatic skills noted with parent
  – Pragmatic skills with SLP
Evaluation Report

Summary

• There is a marked difference between his/her described verbal skills at home, and those used outside of the home. His/her pragmatic language skills as observed are good, fair/poor. This also interferes with his/her ability to communicate with his/her teacher in times of need (requesting bathroom breaks) or reporting when he/she is ill, hurt, or bothered by another person, adult or child.
Evaluation Report

Recommendations

• Speech therapy to aid in improving his/her communication skills in a hierarchical manner (easy to more difficult communication settings) is recommended. In addition, his/her pragmatic language skills need to be addressed through this process.

• Finally, as this suspected disorder is often based on anxiety, assessment and treatment as indicated by a psychologist/psychiatrist is suggested.
IEP vs. 504 Plan?
Access to Direct Treatment

• Often, does not qualify for IEP
  – Language and articulation are “normal”
  – Family provides video of child communicating in home

• May qualify for 504 Plan
  – Part of Americans with Disabilities Act (ADA)
  – Spells out the modifications and accommodations that will be needed for these students to have an opportunity perform at the same level as their peers
IEP or 504?

• Decide as a team
• IEP or 504?
• IEP: Review multidisciplinary team reports. Decide if there is an adverse affect on educational performance and what services would be needed.

• 504: SM affects child’s social/emotion well being and ability to communicate. It’s a disability that limits the major life activity of speaking; therefore would qualify for a 504.
IEP

• Review multidisciplinary team reports.
  – Speech-language pathologist
  – Psychologist
  – Classroom teacher
• Decide if there is an adverse affect on educational performance and what services would be needed.
  – Pragmatics
  – Receptive/expressive language
  – Articulation
  – Voice (volume)
Examples of 504 Plan Modifications

• Tape verbal homework
  – Spelling words
  – Class presentation
• Written for oral communication
• Pair with “buddy”
• Communication cards
  – PECS
  – Self made
• AAC Device

Accommodations/Seating

• Next to a buddy or familiar friend or neighbor
• Near the back (allows student to speak without being seen or overheard; increases privacy)
• Away from classroom exit (this is an area of increased traffic and less privacy; increase perception of “onlookers”)
• Near the teacher (if there are learning issues and student is comfortable with the teacher)
Accommodations

• Away from the teacher (if the student feels more comfortable with classmates than the teacher)
• In group seating arrangements, place peer next to student not across (eliminates the eye contact and makes it easier to whisper into neighbor’s ear).
• Pair with a buddy (bathroom, recess, lunch, hall, field trips)
• Gradually add other students to group of buddies
• Provide as much small group work as possible
• Allow nonverbal communication at first
Accommodations

- Ask choice, direct, or yes/no questions
- Allow extra time to respond
- Extended time for class work as necessary
- Provide rewards for achieving goals
- Use of rating scale to assess level of comfort/anxiety
- Adjust large group expectations (ex: circle time)
- Allow audiotape or videotape for show-n-tell
Accommodations/Consultation

• Allow parents to have access to school on off hours (arrive early, stay later, summer hours)
  – spend time with child in the school environment without others around to promote comfort
  – promote “verbalization” when alone with parents and a close friend
• Allow parents to remain in the classroom for a short time in the mornings to help student become more comfortable
• Minimize eye contact
• Provide warning and preparation for changes in routine
Intervention Strategies
Common Themes to Successful Treatment

• Combination of behavioral and family therapy
  – Speech therapy is part of behavioral process

• Collaboration of school and family
  – Consistent reinforcement paradigm
  – Natural reaction and reinforcement

  • Harris, H, (1996), Elective Mutism: A Tutorial, Language, Speech, And Hearing Services In Schools Vol. 27
General Guidelines

• Establish rapport.
• Gain speech via escape/avoidance technique.
• Provide daily, systematic rewards.
• Use multiple sites for interventions.
• Persistently increase demands.
• Maintain a close, empathic relationship.
• Vary interventions across sites.
• Allow the child to choose behaviors.
• Use creative approaches at stalemates.

• Giddan, 1997
Don’ts

• Don’t make a big deal if the child talks or doesn’t talk.
• Don’t mention that you heard child speak
• Don’t pressure to speak via bribing or repeated asking
Progression

• Non-verbal – Full Voice
  – Gestures, pictures, written
  – Whispering
  – Vocalization
    • Non and true words
  – Soft voice
  – Full voice


Vanessa 10 9 whisper beginning.mpg
Levels of Communication

• Non Communicative

• Non verbal Communication
  – Gestures, head nods

• Transition to Verbal Communication
  – Use of sounds, AAC device

• Verbal Communication
  – Approximated speech – functional speech
Activities

• Plan activity at level of child’s current level
• Non-communicative
• Non-verbal
• Transition to verbal
• Verbal
Social Hierarchy

- Child and parent/sibling
- Child, parent and SLP (observe, comment, communicate)
- Child and SLP
- Child, SLP and unfamiliar observer
- Child, SLP and unfamiliar communicator
- Child and unfamiliar communicator
Social Hierarchy

• Child, SLP and familiar observer
  – familiar observer
    • Teacher, neighbor peer/classmate
• Child, SLP and familiar communicator
• Child and familiar communicator
• If location of treatment is not school, may want to arrange for visit to school
Techniques within Social Hierarchy

- Shaping
- Stimulus fading
- Pragmatic language functions
- Social interaction
- Increasing levels of complexity
Options for the First Session

“How do I get this child to talk?”

• Aim for interaction, even if limited
• Preferred
  – Child and parent
  – Child, parent and SLP  Video
• Allow supports
• Alternative
  – shaping
Use of Social Hierarchy

- Child and parent
- Child, parent and SLP
- Child and SLP
Shaping

• This technique may be beneficial during the evaluation and or first session in getting the child to interact (non vocally, vocally or verbally) with the therapist

• Reinforce mouth movements that approximate speech (i.e. whispering) until true speech is achieved (ASHA.org)

• Moving from non vocal acts (sticking out tongue) to non vocal blowing, to voicing (non-words), to slowly introducing true words in a variety of situations
Shaping Vocal- Verbal Skills
Warm-up Activity

• Work from non verbal, vegetative oral movements to meaningful speech
• May use computer program as third party, impersonal reinforcer
  – Video Voice, Visi Pitch, computer game, but can use any non clinician feedback or not
Shaping Nonvocal to Speech Strategy

• Shaping vegetative – verbal
  – Imitate oral positions
    • Show teeth, stick out tongue
  – Add air movement
    • s, th, f, sh
  – Add stop
    • p, t, k, ch
  – Add voice
    • z, v, b, t, g
  – Add vowel
    • Create CV or CVC words
      – Me, no, mom

• Non threatening
• Offer choices
• Back off and revisit task
Just a reminder...
Do Not Pass Go until...

• You have earned child’s trust
• You have developed positive rapport
• Attend to Cues from Child
  – Gentle advance to next level, stop and retreat when activity too difficult
Stage Interaction with Unfamiliar Observer/Communicator

• “Observer” comes to therapy room, just to “learn how to play game”
  – Sit out of “circle” of SLP and child
• “Observer” comes into circle of SLP and Child
  – Just to watch
• “Observer/Communicator” and SLP change positions
• Do not go to next stage until child is verbal with current one
Pragmatic Language Functions

• Various levels of SLP support to fading
  – How to get someone’s attention
  – How to enter a conversation
  – How to respond
  – How to comment
  – How to ask a question
  – How to end a conversation

• Role Playing
Stimulus Fading

• Slowly transfer speaking responsibilities from the SLP to the child
• Increase difficulty level by increasing child’s responsibilities
Example of Stimulus Fading

• Knock on door
• Introduce self/child
• Describe task (we are taking a survey)
• Ask question
• Closing task (thank you – bye)
Stage Interaction with Unfamiliar Communicator (UFC)

- SLP and child compose structured activity
- SLP and child go to UFC’s room
  - Knock on door
  - Introduce selves
  - Describe activity
- Child performs activity with level of support from SLP as needed
Interaction with UFC

• SLP: knocks on door
• SLP: Hi, this is my friend Sally
• SLP: “We are on a scavenger hunt and want to see if you have something on our list. Do you have a....”
• **Child: “paper clip”**
• UFC: offers response
• SLP: Thanks, Bye, (initially no pressure of child to respond)
Fade SLP’s Support

- **Child:** knocks on door
- **SLP:** “Hi, this is my friend Sally”
- **SLP:** “We are on a scavenger hunt and want to see if you have something on our list. Do you have a....”
- **Child:** “paper clip”
- **UFC:** offers response
- **SLP:** Thanks, Bye, (initially no pressure of child to respond)
More Fading

• Child knocks on door
• Child: “Hi, My name is Sally.”
• SLP: “We are on a scavenger hunt and want to see if you have something on our list.
• Child: Do you have a paper clip.”
• UFC: offers response
• SLP: Thanks, Bye, (initially no pressure of child to respond)
Location of Treatment

• Therapy room
  – Invite UFC into room
• Visit UFC who came to therapy room
• Visit new UFC in their setting
• Invite child’s world into therapy room
  – Friend, neighbor, teacher
• Visit child’s world
  – School visit

Supports

- Allow child to whisper
- Use voice amplifier
- Use walkie talkie
- Have child look at SLP while doing verbal task with outside person
- Allow child to look at words, pictures during verbal act
- Read responses
- Offer non verbal choice

Video
Desentization

- This is the work of the mental health specialist
  - May be a by product of well constructed speech therapy
- Build hierarchies
  - Similar to fluency therapy hierarchy
- Discuss if activity is “easy, medium, hard”
- “Feelings thermometer” *
# Rate Speakers, Situations

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Case Studies
Questions?

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