SELECTIVE MUTISM: EVALUATION AND STRATEGIES FOR INTERVENTION

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SHE'S GIVEN UP TALKING
PAUL MCCARTNEY

Don't say a word
Even in the classroom
Not a dickie bird
Unlike other children
She's seen and never heard
She's given up talking
Don't say a word

You see her in the playground
Standing on her own
Everybody wonders
Why she's all alone
Someone made her angry
Someone's got her scared
She's given up talking
Don't say a word

Ah but when she comes home
It's yap-a-yap-yap
Words are running freely
Like the water from a tap
Her brothers and her sisters
Can't get a word in edgeways
But when she's back at school again
She goes into a daze

https://www.youtube.com/watch?v=0dNfUourn9k

MEDIA WEBSITES

http://www.youtube.com/watch?v=r9f-84BpMpI&feature=related

GOALS

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

WHAT IS SELECTIVE 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

Diagnostic and Statistical Manual of Mental Disorders

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

- Bergman, R. et al, (2000), Prevalence and description of selective mutism in a school based sample. Journal of American Academy of Child and Adolescent Psychiatry, v. 41, pp 938-946
- Lindsay BA, Pescosolo J, McCracken JT (2002). Prevalence and description of Selective Mutism in a school-based sample. Journal of the American Academy of Child &Adolescent Psychiatry, 41(8):938-946. [ADJ]

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%

- **Selective mutism and social anxiety disorder: all in the family?** (2007) **Chavira DA, Shipon-Blum E, Hitchcock C, Cohan S, Stein MB.** J Am Acad Child Adolesc Psychiatry
- Black, B. i Uhde, T. (1995) Psychiatric Characteristics of Children with Selective Mutism: A Pilot Study. J of the American Academy of Child & Adolescent Psychiatry; 34(7):847-856

FAMILY GENETIC LINK

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

- Jackson, M., Allen, R., Boothe, A., Nava, M., Coates, C., (2005) Innovative Analysis and Interventions in the Treatment of Selective Mutism. Clinical Case studies. 4 (1) 81-111.

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

- Jackson, M., Allen, R., Boothe, A., Nava. M., Coates, A., Innovative Analyses and Interventions in the Treatment of Selective Mutism, *Clinical Case Studies* 2005; 4; 81

ASHA

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

- ASHA.org
- Keen, D., Fonseca, S., and Wintgens, A., (2008). Pathway of Good Practice Selective Mutism: A Consensus Based Care. Arch. Dis. Child.; 93 :838-844

PLAYERS

- Physician
- 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 desensitization
  - 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
  - Input from other players

SPEECH-LANGUAGE PATHOLOGIST

- Assess child's communication
- Treat functional communication
- Treat true speech and language issues
- 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 (anxiety) 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

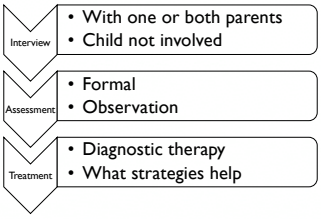
FAMILY DYNAMICS

- 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

PARENTS' PERSPECTIVE

WHERE TO START

- Assess child's communication
- Educate and counsel
  - Family
  - Teachers
- Bring players together
- Treat functional/real communication disorder



QUESTIONAIRE

- Gives family time to respond, and not be "on the spot"
- Create your own

Bergman RL, Keller ML, Piacentini J, Bergman AJ. The development and psychometric properties of the Selective Mutism Questionnaire. J Clin Child Adolesc Psychol. 2008

QUESTIONNAIRE

- 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

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

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

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
  - Remind 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
- If needed, have a familiar person administer evaluation
  - Expressive language
  - Articulation
- Allow frequent breaks of needed

ASSESSMENT TIPS

- Allow supports
  - Non verbal supports
  - Parent close by
  - Physical comforts

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"

SM VS. GENERAL POPULATION

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

Klein, R., Armstrong, L., Shipon-Blum, E., 2012 **Assessing Spoken Language Competence in Children With Selective Mutism: Using Parents as Test Presenters, Communication Disorders Quarterly.**

COMMUNICATION DEFICITS IN SM POPULATION

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

Klein, R., Armstrong, L., Shipon-Blum, E., 2012 **Assessing Spoken Language Competence in Children With Selective Mutism: Using Parents as Test Presenters, Communication Disorders Quarterly.**

SUBTLE LANGUAGE DIFFICULTIES?

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

- McInnes, A., Fung, D. Manassis, L., Fiksenbaum, L., Tannock, R., (2004) Narrative Skills in children with Selective Mutism, American Journal of Speech-Language Pathology, Vol 13, pp 304-315

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

Klein, R., Armstrong, L., Rosen-Blum, C. 2017 **Assessing Spoken Language Competence in Children With Selective Mutism: Using Parents as Test Presenters, Communication Disorders Quarterly.**

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

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
    - Direct treatment
    - School modifications

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

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.

DIRECT VS. INDIRECT TREATMENT

HANDS ON TREATMENT

MODIFICATION OF ENVIRONMENT

ACCESS TO DIRECT TREATMENT

- Often, does not qualify for school based speech/language therapy (US)
  - Language and articulation are "normal"
  - Family provides video of child communicating in home
- May qualify for modification 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

DIRECT TREATMENT/ MODIFICATIONS

- Decide as a team
- Direct treatment: Review multidisciplinary team reports. Decide if there is an adverse affect on educational performance and what services would be needed.
- Modifications needed in school environment

NEED FOR TREATMENT IN THE SCHOOL SETTING

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 SCHOOL MODIFICATIONS

- Tape verbal homework
  - Spelling words
  - Class presentation
- Written for oral communication
- Pair with "buddy"
- Communication cards
  - PECS
  - Self made
- AAC Device

- Kee,C., Fung,D., Ang,L. Letter to Editor (2001) American Academy of Child and **Adolescent** Psychiatry

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

INTRO TO INTERVENTION

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

- Giddan, J. Ross,G , Seehler, L, Becker, B (1997) Selective Mutism in Elementary School: Multidisciplinary Interventions, Lang Speech Hear Serv Sch, 28: 127 - 133.

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
- Allow supports
- Alternative
  - shaping

USE OF SOCIAL HIERARCHY

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

PARENT TO SLP INTERACTION

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 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

SHAPING VOCAL-VERBAL SKILLS

- 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

STAGING INTERACTION WITH UNFAMILIAR OBSERVER/COMMUNICATOR

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

STAGING INTERACTION WITH UNFAMILIAR COMMUNICATOR (UFC)

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/classroom visit

VISIT SCHOOL

- Start outside of classroom with same routine

GUIDING PROGRESS

- Give child power to make choices
  - Nudge on as needed

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

DESENTIZATION

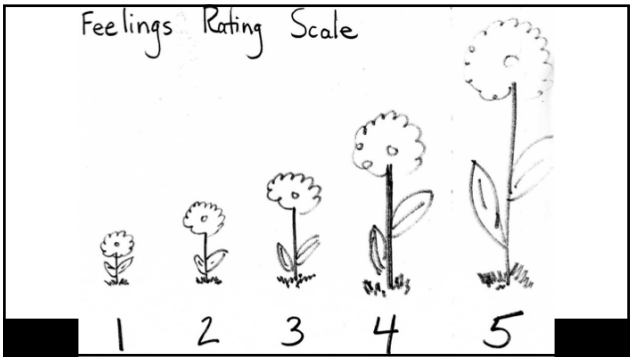
- This is the work of the mental health specialist
  - May be a by product of well constructed speech therapy
- Build hierarchies
  - Similar to fluency therapy hierarchy

CHECK CHILD'S COMFORT LEVEL

- Discuss if activity is "easy, medium, hard"
- "Feelings thermometer" *

Vanessa discuss soft vs loud voice preference.mpg

• Jackson, M., Allen, R., Boothe, A., Nava, M., Coates, C., Innovative Analysis and Interventions in the Treatment of Selective Mutism. Clinical Case studies.



RATE SPEAKERS, SITUATIONS

Easy Easy	Medium Middle	Difficult Hard

RATE SPEAKERS, SITUATIONS

Easy	Medium	Difficult
Mom	Kristen	Mrs. Landers

RATE SPEAKERS, SITUATIONS

Easy	Medium	Difficult
Mom	Mrs Landers Kristen	

CHILD'S PERSPECTIVE

CASE STUDY #1

- 9 year old with history of selective mutism
- Very supportive family
- Verbal in all environments except school.
- Followed the protocol for first session.
- Child verbal with therapist during the first session
- Seen bi-weekly in treatment.
- Now what….???

CASE STUDY #1 LETS TALK TO MORE PEOPLE!

- Made surveys to encourage child to interact with others in a very structured way
- PRAGMATICS
- How to respond when someone asks a question
- How to end a conversation.

CASE STUDY #1 CARRYOVER

- Made surveys to be completed at school
- This was too hard – so complete the surveys on the bus
- Completed hard, medium, easy to talk to worksheets bi-weekly
- Completed homework sheet bi-weekly
- Goal was to integrate child into a social group at the hospital
- Attempted to set up session with teacher

CASE STUDY # 1
MOTHER'S REPORT ON PROGRESS

CHILD'S PERSPECTIVE

CASE STUDY #2

- 7 year old child, non verbal outside of home
- Referred by psychiatrist
- Has seen psychotherapist, and after two sessions, stopped talking at home
- Discontinued psychotherapy

CASE STUDY # 2

- Seen in Speech Pathology
  - Normal receptive language
- Admitted to day treatment for 2 weeks
- Continued out patient speech therapy
  - When verbal, "disguised" speech
    - Nasal in clinic (normal resonance at home)
    - Used Nasometer as objective feedback
    - Gained normal resonance

CASE STUDY #2

- Struggled with various aspects of program
- Fearful of being verbal at school
- Cognitive

CASE STUDY #2 PROGRESS OF THERAPY

- Followed protocol
- Brought "friend" from school to therapy
  - Very anxiety producing
- SLP met with child and friend separately
- Used "Friend" as observer sequence
- Results: child remained verbal with child

CASE STUDY #2
VISIT TO SCHOOL

- SLP met with child in non-classroom
- Engaged in familiar game
- Invited classmate into room
- Invited teacher into room
- Moved to classroom
  - Goal: SLP and child verbal

CASE STUDY #2
COGNITIVE

Easy	Medium	Difficult
Mom	Jan	Teacher
Sister, Katie	People I don't know	My friend at school, Tori

CASE STUDY #2
COGNITIVE

- Sometimes I think things will be scary
- But when I try to use my voice, the scariness goes away
- Mantra:
  - The more I talk, the easier it gets

CASE STUDY #3

- 5 year old, verbal at home, not outside, but would talk to mother with others nearby
- Child would talk to mother outside of home (would be heard talking in waiting room)
- Used protocol with good results in and out of therapy room
- Family very concerned regarding ability to transfer verbal skills to school

CASE STUDY #3

- Prior to first day of school
  - Met with child in her classroom, engaged in activity
  - Teacher joined in activity
    - Initially observed activity, then joined in
  - Child remained verbal first day at school and continued.

CASE STUDY #4

- 17 year old female
- Became mute in school when moved from a small junior high to a larger high school
  - Had a history of selective mutism as a preschooler
  - As preschooler, was treated by SLP and psychologist

CASE STUDY #4

- Reported that she always felt "anxious" and battled speaking, but this was not apparent to others
- Saw psychologist
- Speech therapy treatment

CASE STUDY #4

- Much of therapy was directive and based on participation in assigned homework
- Cognitive
- Behavioral
  - Arranged response in classroom with teacher
  - Arranged response in small group with peer
  - Made phone call to order pizza

CASE STUDY #5

- 3 year old female
- Selective Mutism just identified when child started day care, 4 months ago
- Parents very open and involved in treatment process
- Child not currently seen by mental health professional

CASE STUDY #5

- Parents have questions regarding how to react to child in social situations
  - Concerned child will appear "rude", impolite
  - Have not begun to "rescue" child
- Child varied from non verbal to whisper

CASE STUDY #5 PROGRESSION

- Involved parent-child only at start of session
- SLP entered room after 5 minutes
  - Observed, then entered activity
- Eliminated parent child only segment
- UFC invited into room
- Visit UFC

CASE STUDY #5

- Child's voice changed
  - Whisper
  - Loud whisper
  - Soft-loud voice

CASE STUDY #5

- Practiced soft loud voice in and out of a communicative setting

CASE STUDY #5

- In new situations, reverts to whisper, but moves through to voicing quickly

CASE STUDY #5

- Parents maintained active participation in therapy
- Child became and remains verbal outside of the home

CASE STUDY # 6

- 10 year old female
- ADHD
- History of not talking in preschool
- Grades in the C-D range
- Presented herself as very angry, non cooperative
- Is in counseling for other issues

CASE STUDY # 6

- Seen for therapy
- Responded to directions/questions with shoulder shrug
- Treating SLP was new at seeing patients with selective mutism
- SLP had difficulty with increasing level of difficulty

CASE STUDY # 6

- Changed SLP
- "Restarted" treatment program
- Started with giving her talking options
  - Verbal vs. pointing to hand to indicate response
- Shoulder shrugs began to disappear

CASE STUDY # 6

- Specific difficulties noted with using the phone
  - Would not talk to mom on phone
- Targeted this step by step,
  - repeating words/phrases after SLP on speaker phone
  - using speaker phone to speak to someone
  - Using handset to ear

CASE STUDY # 6

- Verbally acknowledged that she needed to be "pushed"
- Now having some difficulty with talking inappropriately
  - talking in class
  - "talking back" to teacher

ON-LINE RESOURCES

- https://www.asha.org/practice-portal/clinical-topics/selective-mutism/
  - Practice portal
- https://www.asha.org/public/speech/disorders/selective-mutism/
- http://www.selectivemutismfoundation.org/
- http://selectivemutismcenter.org/
  - has many excellent handouts
- http://www.selectivemutism.org/
  - requires membership

EDUCATING SCHOOL STAFF/FAMILY MEMBERS

- Borrow or purchase these books:
  - Helping Your Child with Selective Mutism: Practical Steps To Overcome A Fear of Speaking by Angela McHolm, Charles Cunningham, Melanie Vanier. (2005) ISBN 1-57224-416-X. or public library.
  - The Ideal Classroom Setting For the Selectively Mute Child by Dr. Elisa Shipon-Blum. (2007)
  - Easing School Jitters for the Selectively Mute Child by Dr. Elisa Shipon-Blum. (2003)
  - Understanding Katie by Dr. Elisa Shipon-Blum (2003).
  - Supplement Treatment Guide to "Understanding Katie" by Dr. Elisa Shipon-Blum. (2004)

Dr. Elisa Shipon-Blum's books can be order from the www.selectivemutismcenter.org website.

QUESTIONS?

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