Selective Mutism
Understanding, Assessing, and Treating

Rebecca Lulai, MA CCC-SLP
Speech-Language Pathologist
Able Speech-Language Services
Associate Clinical Specialist
University of Minnesota

A child with selective mutism should be seen by a speech-language pathologist (SLP), in addition to a pediatrician and a psychologist or psychiatrist. These professionals will work as a team with teachers, family, and the individual.

* Taken from ASHA website search for Selective Mutism: http://www.asha.org/public/speech/disorders/SelectiveMutism.htm

• Responsibilities when assessing a student with dysfunctional social-emotional communication include.......• Assisting educators in identifying behavior patterns that may be related to language dysfunction as well as identifying behavior that negatively affects communication (e.g., selective mutism).....

• Guidelines for the Roles and Responsibilities of the School-Based Speech-Language Pathologist
• American Speech-Language Hearing Association, 2000

Social-Communication Anxiety Disorder

• Anxiety impairs ability to utilize language skills
• Children with SM FREQUENTLY have communication disorders.
• SLPs know Communication!

Today’s Topics

• Understanding
• Assessment (including eligibility)
• Intervention
• Case Management
• Accommodations
• Special Circumstances
Selective Mutism
Social Communication Anxiety Disorder

- Not just “anxiety”
- Not just “shy”
- Not just “not talking”
- A neurological response: lower threshold of excitability in the amygdala, protective response
  - Dunaway (2006)

Prevalence of SM in US

- 1 in 143  Bergman, RL et al (2002)
  - n = 2256
  - n = 190

More prevalent in girls than boys.

Common Characteristics

- Genetic predisposition
- Social anxiety and/or social phobia
- NOT defiance, NOT a choice
- Amygdala excites more easily and for a longer period of time than “normal”
- Mutism is a reflexive protective response

What does it look like?

- avoid initiating, avoid answering phone
- clinging, hiding, running away to another room
- panic like symptoms, tummy aches, headaches
- freezing, blank and expressionless, random meltdowns

What does it feel like?

- “the words get stuck between my toes”
- “I want to answer his questions but I can’t move or do anything but wait until that feeling goes away”

- Highly sensitive to surroundings
- Bright, introspective, observant
- typically presents as entering preschool or school (social and language demands are greater)
Shyness vs. Selective Mutism

**Shyness**
- “warm up” period
- Can respond with a nod or small smile
- Same demeanor everywhere – quiet and reserved

**Selective Mutism**
- Might never “warm up”
- Cannot respond at all - may appear frozen
- Dual personality – restrained at school and talkative at home

Diagnostic Criteria from DSM-4

- 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.

Diagnostic Criteria from DSM-4

- The disturbance interferes with educational or occupational achievement or with social communication.

Diagnostic Criteria from DSM-4

- The duration of the disturbance is at least 1 month (not limited to the first month of school).

Diagnostic Criteria from DSM-4

- The failure to speak is not due to a lack of knowledge of, or comfort with the spoken language required in a social situation

Diagnostic Criteria from DSM-4

- The disturbance is not better accounted for by a communication disorder (stuttering) and does not occur exclusively during the course of a pervasive developmental disorder, schizophrenia or other psychotic disorder.
Speech-Language in kids with SM

- 4 of 5 kids with SM have receptive or expressive language delays/disorders
  - Cleator & Hand (2001)

- 43% scored in “clinical range” for speech-language disorders—parent interviews

Speech-Language in kids with SM

—“shorter, linguistically simpler, less detailed narratives... when retelling story at home and clinic. Despite normal receptive and nonverbal cognition”

Speech-Language in kids with SM

- 30-63% of kids with SM have communication impairment
  - Kristensen (2000)

- Decreased receptive skills compared to kids with anxiety and no SM and to “typical” kids

Myth Busters

- These kids WANT to talk!
- may qualify for special ed services.
- SLP should be involved from the beginning.
- Parents may not know

Myth Busters

- No consistent evidence of link to psychological trauma
- Don’t wait and see. Early intervention!
- Any level of SM makes a child miserable. Give them some help.
ASSESSMENT TEAM

• Parents
• Teachers
• SLP
• School Psych
• Outside therapy
• Special Ed Team
• Physician if medical issues
• Other care providers or family members

All evaluators must understand SM!

What do we need to know?

1. Does this child have SM?
2. What are the specifics of the behavior?
3. Why does this behavior continue?

1. Does this child have SM?

• Official diagnosis from physician or mental health professional

• Educational setting: school psychologist

• An official diagnosis is not necessary to qualify for services.

2. Specifics of behavior?

• Selective Mutism Questionnaire:
  • measures severity of sm and progress over time
  • normed with others with sm and those without
  • Not created to diagnose

• School Speech Questionnaire: for teachers to complete

3. Why does behavior continue?

• How do others respond?

• Are people enabling intentionally?

• Are people enabling inadvertently?

• Are there people pushing them to talk?

• Friends talking for them can be enabling.
Assessment Planning

- General behavior rating scales
- Overall cognition
- Academic performance
- Health/Sensory
- Communication

Assessing Communication: Tips BEFORE you test

- Anxiety negatively affects performance
- Establish comfort... social engagement
- Be aware of what anxious behaviors look like
- Never talk about “testing”, always “games”

Assessing Communication: Tips BEFORE you test

- Stop testing if signs of anxiety or shutting down
- Be aware of precipitating factors:
  - Time of day, day of week, occurrence of breaks
- Results won’t be optimal unless the anxiety is reduced.

When they just don’t talk

OPTIONS

- Behavioral rating scales
- Videos of interactions at home (give the parents specific tasks)
- Clinical observations

When they just don’t talk

OPTIONS

Current research:

- Train a parent or other adult to administer test
- Scored and interpreted by qualified professional
- Klein (2010) parents are 96-97% accurate in administration of tests
Pragmatic Language: Behavior Rating Scales

- CELF-Pragmatics Profile
  - (Ages 5-21)
    » Criterion referenced, statistically stands alone
    » This is not a subtest

Pragmatic Language: Behavior Rating Scales

- Social Skills Improvement System
  - (Ages 3-18)
    » Provides standard scores
    » Correlates to “goals and intervention system”

Pragmatic Language: Behavior Rating Scales

- Children’s Communication Checklist-2
  - Ages 4-16 yrs
    » Provides standard scores
    » Communication and pragmatic language

Receptive Language

- Peabody-Picture Vocabulary Test-4
  Ages: 2.6 to 90+
  - Nonverbal
    » Provides standard scores
    » Strongly correlates to Verbal IQ

Receptive Language

- Lindamood Auditory Conceptualization Test -3
  Ages 5 to 18-11
    » assesses phonemic awareness and processing skills
    » criterion referenced

Receptive Language

- Test of Auditory Comprehension of Language-3
  - Ages: 3.0 to 9-11
    » Non-verbal
    » Provides standard scores
Receptive Language

Portions of CELF-4:
- Concepts and Directions (subtest)
- Word Association:
  » criterion referenced
- Phonological Awareness:
  » criterion referenced
- Rapid Automatic Naming:
  » criterion referenced
  » Processing speed and accuracy

Expressive Language

- Expressive Vocabulary Test-2:
  - Ages 2:6 to 90+
  » limited verbalizations required
  » provides standard scores

Expressive Language

- Test of Narrative Language:
  - Ages 5-11
  » story comprehension and retelling
  » Provides standard scores

Expressive Language

- Strong Narrative Assessment Protocol:
  - (SNAP)
  - Ages 7-11
  » structured way to analyze language sample
  » Does not provide standard scores

Expressive Language

- Language Assessment, Remediation and Screening Procedure (LARSP)
  » Free download
  » Method of analysis, not a test

Articulation and Fluency

- Smit-Hand Articulation and Phonology Evaluation
  - Ages 3-9
  » Provides standard scores
  » Normed based on pre-recorded productions from home
- Goldman-Fristoe -2
- Clinical Assessment of Articulation and Phonology
  (2;6-8:11)
  » Provides standard scores
- Analysis of recorded speech samples if > age 9

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ELIGIBILITY and LABELS

- Emotional/Behavioral Disorder
- Other Health Impairment
- Speech-Language Impairment
- Developmental Delay

Emotional/Behavioral Disorder

Pros
- Gets the direct service

Cons
- Only recognizes the anxiety
- Does not recognize the communication impairment
- Misleads teachers/staff
- Perpetuates the myth of defiance
- Can lead to inappropriate programming or classroom placement

Other Health Impaired

Pros
- Gets direct service
- Means that the family is getting outside help
- Is not as negatively perceived as other labels

Cons
- Diagnosis from physician or mental health practitioner is not always available.

Developmental Delay

Pros
- Gets direct service
- Any services can be provided as needed
- Skills can be addressed as an ECSE team

Cons
- Only until age 7
- May be misinterpreted as cognitive delays
- May lead to inappropriate classroom placement

Speech-Language Impairment

- Acknowledges communication and pragmatics
- Direct service by communication specialist
- Directly address co-existing speech and/or language issues
- Not perceived as negatively as other labels

Speech-Language Criteria

- 2.0 Standard Deviations or more below mean on 2 norm-referenced, technically adequate language tests

OR

- 2 documented measurement procedures indicating a substantial difference from expectations, based on age, developmental level or cognitive level
IEP? Or 504?

- Which do you need to......
  - Increase social comfort
  - Decrease anxiety
  - Progress in communication skills
  - Fully access education
  - Reach academic potential
  - Address co-existing conditions

IEP or 504? Considerations

- Often with accommodations only, the child will get “stuck”, not continue to make progress
- An IEP does not guarantee progress, needs to involve the right interventions
- These kids qualify for 504 without question. SM affects the major life activity of speaking

Intervention

- Considerations for Speech/Language
- Social Communication Scale
- The Bridge
- Principles of Intervention
- Activities to Cross the Bridge

Co-existing Speech/Language Imp

- Must have social engagement and child easily talking with you in the speech room before addressing errors in speech areas
- Best 1:1 at first, then small group of kids with whom he/she will talk

Co-existing Speech/Language Imp

- Friendship groups: to increase social engagement with those kids
- those kids can have speech issues, but the goal for your sm kid is only social engagement at that time
- Once comfort is established, proceed traditionally, but be mindful of bridging up and down

SM-STAGES OF COMMUNICATION COMFORT SCALE  (Dr. Elisa Shipon-Blom)

- Mutism
  - Stage 0: No Communication
    - No responding
    - No initiating
    - child stands motionless, expressionless, frozen-looking

- Speaking
SM-STAGES OF COMMUNICATION COMFORT SCALE
(Dr. Elisa Shipon-Blom)

Communicative
Stage 1: Nonverbal Communication

- 1A. Responding
  pointing, nodding, writing, using sign language, etc.

- 1B. Initiating
  getting someone’s attention via pointing, raising one’s hand, etc.

**Need Verbal bridge to move from Stage 1 to 2.**

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Stage 2: Verbal Communication

- 2A. Responding
  any sounds, e.g., grunts, baby talk, animal sounds, moans, soft whispering, speaking

- 2B. Initiating
  getting someone’s attention via making any sound

** Verbal bridge helps to transfer speaking to an environment, a person or an object. **

** Ability to respond/initiate determined by ‘comfort’ in setting. Communication varies from setting to setting. **

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The BRIDGE Dr Elisa Shipon-Blum

• Use the bridge to transition across stages, environments, people, situations, etc

• Different spots on the bridge in different contexts

• It is common to fluctuate up and down on the bridge as he/she progresses

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Principles of Intervention

• Early Intervention
• Decrease Anxiety
• Increase Social Engagement
• Contingency Management
• Team Approach
• Track and Monitor
• Practice, Practice, Practice
• Integrate Initiation
• Build relationships

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Importance of Early Intervention

- Minimize negative impact
- Prevent from becoming worse
- Prevent from becoming engrained/conditioned
- Prevent repeated ineffective attempts to elicit speech
- Minimize emotional/physical strain on parents and teachers

Decrease Anxiety

- Take the pressure off! No bribing, coercing, punishing.
- Remove the expectation of speech.
- Calm and supportive environment (no big deal)
- Provide other methods of successful communication
- Daily monitoring of anxiety
  - By child
  - By teacher
  - By parent

How big is your worry?

How scary would it be…?

Increase Social Engagement

- precursor to communication, more engagement leads to spontaneous communication
  - Meet them where they are and stimulate the next step
  - Successive approximations
  - Exposure training
  - Hierarchy of interactions
  - ERRORLESS TRANSITIONS!
  - Success begets Success!

Contingency Management

Make social engagement more rewarding than avoidance

- Motivation, reinforcement, incentives (not bribes)
- Never take away a reward that has been earned legitimately
- Tips for setting it up
Involve and Educate the Entire Team

Members

• Parents
• Grandparents
• Teachers
• Specialists
• Lunch Staff
• Recess Staff
• Other classroom teachers
• Daycare providers
• Principal
• Office Staff
• Custodial Staff
• Outside Professionals

Considerations

• Everyone the child comes in contact with throughout the day, all on board.
• Teachers spend the most time with the kids, educate them
• Educate the entire team: give specific instructions for how they should initiate or react
• Include outside professionals when possible

Track and Monitor

—Track what strategies work to reference in “backslides”

—Visual record of child’s accomplishments and goals

BRAVE GOALS

Date_____________________

School/classroom  My Office
1. 1.
2. 2.
3. 3.

Friends  School/bonus places
1. 1. library
2. 2. lunch
3. 3. playground

People I WANT to talk to

Grandpa
Friend Izzy
Friend Tessa
Teacher Mrs. Smith
Uncle Bob
Waitress
Friends on the phone
Piano/music teacher
Lunch ladies
Principal

People I CAN talk to

Mom
Dad
Grandma
Friend Grace
Friend Abby
Aunt Becky

“I CAN Chart”
Brave Timeline

Brave Journal
- Annie handed her menu to the server at Perkins.
- Annie waved to the lady in the office when we signed in.
- Annie rang the bell at the end of indoor recess.
- Annie told mom’s friend how old she is by holding up her fingers.
- Annie said “no, thanks” to the lunch lady.
- Annie showed her talking picture at show and tell.

Practice, Practice, Practice
- Provide numerous opportunities
- Multiple times a day
- Do not stop engaging the child because he/she is mute

Practice, Practice, Practice
- Manipulate the environment to increase opportunities
- Gentle Sabotage
- ERRORLESS!
- Plan, do, review with the child

Integrate Initiation
- Could be verbal in responding, but frozen when initiating
- Nonverbal games can become “beat the clock” activities
- Nonverbal role in activity (time keeper, referee, buzzer role)
- Hand over/take over
- Scavenger hunts

Build Relationships
- Pair with kids he/she talks to for group projects
- Place in same classroom with kids he/she talks to
- Outside activities with a friend
- Bus/lunch/recess buddies
- Keep increasing the diameter of the circle
Bridging Stage 0-1
No Responding, No Initiating..................to Nonverbal

• **Goal: increase social engagement** (successive approximations)
  – Hand over/take over
  – Waving (with and without looking)
  – Parallel play (no-speaking required)
  – Non-verbal turn taking games (Old Maid, Tic Tac Toe, Bingo)
  – Draw pictures

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Bridging Stage 0-1
No Responding, No Initiating..................to Nonverbal

– Non-verbal Scavenger hunts
– Take pictures of people
– Mailperson to engage with teachers
– Teachers/staff writing letters to send home
– ANY exchange of communication (non verbal or verbal is accepted)

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Bridging Stage 1-2
Nonverbal..............to Transitioning

• **Goal: increase social comfort with responding AND initiating**
  – Answer yes/no questions with gestures
  – PECS (embedded initiation)
  – Pointing, gesturing, choice boards, picture menus
  – Writing or drawing pictures (portable white board to get a message across

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Bridging Stage 1-2
Nonverbal..............to Transitioning

▫ Develop signal or meeting spot for child to initiate
▫ Getting attention with noise
▫ Clock watcher job: indicate that time is up (engages child in peer activities)
▫ Match musical instruments, body/mouth noises (desensitize the children to hearing and making noises)
▫ Non-voice augmentative devices, texting or email for older children

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Bridging Stage 2-3
Transitioning......... to Verbal

• **Goal: transition to verbal communication**

  ▪ **Speech Generating AAC devices:**
    • single message devices, digital picture frames for show and tell, text to speech on ipod touch
    • Let’s them hear their voice
    • 1st step before other steps
    • Use as accommodation in classroom

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Bridging Stage 2-3
Transitioning......... to Verbal

• **Goal: transition to verbal communication**

  ▪ **Verbal Intermediary/Key Worker/Buddy**
    • Allows for communication to one person/object, then share with the group
    • Use Animals, Puppets or people they can talk with comfortably
    • Whispers: slowly increase the distance

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Bridging Stage 2-3
Transitioning............ to Verbal

- **Ritual Sound Approach:**
  - Works well for speech phobic
  - Shape noises (voiceless sounds into letter sounds, name the sounds (popcorn sound or bee sound)
  - Shape sounds into words “blendy sounds” = CV combos for word approximations
  - Shape words into sentences
  - Add a person at a time

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Stage 3 and Beyond
Verbal Communication

- **Goal:** verbal communication in all settings
  - Quiet speaking (1:1)
  - Whispering is a normal transitional stage and will fade
  - Scripts for high frequency scenarios
  - Altered speech
  - Questionnaires to teachers, outside friends

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Tips for Case Management

- Meet often
- Modify goals frequently
- Communicate among the team
- Choosing appropriate class placement
- Educate teachers and staff
- Plan transition for next year early

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Accommodations

- Main purpose is reduce anxiety
- Differ student to student, based on needs
- Be careful not to enable mutism
- Train the sub
- Utilize aides/paras to reduce negative effects of mutism and ensure others are not enabling.
- Arrange class schedule to allow time to “ramp up”
- See handout

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Complicating Factors

- Co-morbid psychiatric issues:
  - Suspicion of trauma or abuse:
    - Involve psych ASAP!
    - Mandatory reporters
    - Intense psych treatment?
    - Medications?

- Cognitive Impairments:
  - same process, slower progression

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Complicating Factors

- **Oppositional Temperament:**
  - intensive behavior management

- **Duration/Age:**
  - if it has been conditioned or reinforced it will be more difficult to treat
  - More likely to be speech phobic

- **Severity:**
  - look at the stages, meet them where they are

References

- Mind Institute: [www.childmind.org](http://www.childmind.org)
- Selective Mutism Group: [www.selectivemutismgroup.org](http://www.selectivemutismgroup.org)
- ASHA: [www.asha.org](http://www.asha.org)

Additional Resources

- **SMart Center:** [www.selectivemutismcenter.org](http://www.selectivemutismcenter.org)
  - Numerous handouts and articles available
- **Selective Mutism Group:** [www.selectivemutismgroup.org](http://www.selectivemutismgroup.org)
  - Numerous handouts and articles available
  - Provider directory (limited)
- **Child Mind Institute:** [www.childmind.org](http://www.childmind.org)
  - Workshops for parents and teachers streamed live online
- **ASHA:** [www.asha.org](http://www.asha.org)
References