

Let's Talk: Trends and Tactics With Selective Mutism



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Disclosures:

Financial: Angela is a Clinical Associate Professor in the Department of Communication Sciences and Disorders at the University of SC and is a salaried employee of the University.

Nonfinancial: No relationships to disclose.



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Defining the Condition: DSM-V Criteria

- Selective Mutism is a complex disorder, characterized by an individual's inability to speak and communicate effectively in select social settings.
- A professional must eliminate the possibility that the individual is unable to speak the language or doesn't have the knowledge about the topic of discussion or questioning.
- The condition must be present for a minimum of a month.
- Communication status must have negative impact on school, occupation, and other activities.
- The professional must rule out other communication disorders (e.g., articulation: **NOTE**: Child CAN HAVE other communication disorders, but those disorder(s) alone cannot be the sole cause of failure to communicate).

Defining the Condition: Additional Notes

- These individuals are able to speak and communicate in settings where they are comfortable, secure, and relaxed.
- Mental health professionals classify it as an anxiety-based disorder.
- It is not merely being “shy”, though it may be thought of as extreme timidity.
- It is not an intentional refusal to speak, though it may be perceived that way.

Defining the Condition: Additional Notes

- Selective Mutism is not a response to trauma, neglect, or abuse.
- It is not the condition known as traumatic mutism, which may occur abruptly as a response to a traumatic event, such as losing a loved one.
- Individual with Selective Mutism is talkative at home with family, but uses gestures in place of speech or will not talk at all in other settings.
- Individual may have emotional outbursts.
- Mental Health Professional must determine that the lack of verbal communication is not attributed to a psychotic disorder.



Defining the Condition: Additional Notes

- Child may be extremely attached to parents.
 - Individual may be described as “extremely shy”.
 - Individual may self-isolate (avoid contact with other individuals).
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What Selective Mutism Is Not, Per DSM-V Criteria

- Individual has never talked in any situation or environment (not at home or other familiar environment).
- Individual was very recently introduced to the language in a particular environment, such as starting school.
- Individual is beginning to learn a second language. Individual may go through a silent period until more confident with speaking. It may take a half year to become comfortable with the language.
- The mutism occurs abruptly in every environment after a traumatic event.
- When failure to communicate is attributed solely to other speech difficulties like articulation, when the individual avoids speaking.

History of DSM Changes

- View the following website to observe how the diagnostic characteristics of Selective Mutism (formerly Elective Mutism) have changed over time:

<https://www.selectivemutismfoundation.org/knowledge-center/articles/view-selective-mutism-in-the-dsm>

Prevalence & Incidence

➔ From ASHA website, (Statistics vary):

-Recent prevalence estimates range between 0.47% and 0.76%. Rates as low as 0.02% and as high as 1.9% have been reported.

-Appears to affect more females than males by a ratio of about 1.5–2.5:1. Equal ratios among girls and boys have also been reported.

-Affects approximately 1% of children being seen in behavioral health settings (American Psychiatric Association [APA], 2000).

-Higher prevalence rates among immigrant children and in language-minority children than in nonimmigrant children.

Prevalence & Incidence

➤ From National Alliance on Mental Illness:

-Prevalence ranges from .03% to 1% but could be an underestimation.

➤ From a 2016 article in the European Journal of Physical and Rehabilitation Medicine:

-Worldwide prevalence rate ranging from 0.2% to 2% among elementary school children.

Beginning Testing & Intervention

- Parent, concerned individual, or clinician suspects the condition.
- Speech, language, and hearing evaluations should be completed to rule out other difficulties.
- SLP may document Selective Mutism suspicion but must refer for mental health evaluation for diagnosis.
- Mental health professional may identify other conditions (e.g., anxiety, depression).
- Treatment by SLP should occur in conjunction with mental health intervention.

Speech-Language Evaluation

- **Complete procedures based on guidelines provided by employer and client's compliance.**
- Detailed case history and parent interview : description [video or audio if possible] of home, school environment and routines
- Observe non-verbal communication.
- Observe verbal communication (whispering, as well as audible phonation)
- Note the communication partners with whom the individual is willing to communicate.
- Note the situations in which the individual is willing to speak (e.g., requesting help, recess).
- Observe evidence of stress or tension in body language or facial expressions.
- If possible, determine individual's self-perception of communication.

Speech-Language Evaluation

- **Complete procedures based on guidelines provided by employer and client's compliance.**
- Formal Testing (May need to employ caregiver in the process)
- Assess receptive vocabulary.
- Assess listening/auditory comprehension.
- Assess pragmatic language.
- Assess expressive language, if possible (vocabulary, syntax, morphology).
- Assess oral narrative or narrative retelling skills.
- Administer the Selective Mutism Questionnaire.

www.oxfordclinicalpsych.com/view/.../med-9780195391527-interactive-pdf-002.pdf

Speech-Language Evaluation

Selective Mutism Questionnaire:

- ▶ 17-item report that is completed by caregivers
- ▶ Evaluates the situations in which child fails to speak
- ▶ Caregivers describe frequency as:
 - 0 (never)
 - 1 (seldom)
 - 2 (often)
 - 3 (always)
- ▶ Child without SM scores average of 46 points. Child with SM scores average of 13 points.
- ▶ Lower SMQ scores indicate that the child talks less frequently than most children.

Selective Mutism Questionnaire

*SMQ Scores for Children With Selective Mutism (SM) Versus Those Without

<i>Domains</i>	<i>SM M (SD)</i>	<i>NonSM M (SD)</i>	<i>t(64)</i>
Total	12.99 (7.23)	46.00 (5.94)	16.05
School	.30 (0.42)	2.65 (0.49)	19.19
Home/Family	1.70 (0.76)	2.90 (0.62)	9.49
Public/Social	.34 (0.45)	2.50 (0.53)	16.43

Note: SM, $n = 48$; NonSM, $n = 18$. Lower scores represent less frequent speaking behavior (more severe SM symptoms). For all values, $p < .001$.



Speech-Language Evaluation

- Assess speech sound abilities
- Assess voice
- Assess fluency
- Screen hearing
- Assess oral mechanism function

Diagnosis by Mental Health Professional

- SLP reports to mental health provider that Selective Mutism is suspected.
- SLP may assign diagnosis of Social Pragmatic Communication Disorder ICD-10-CM code **F80.82**).

Collaborative Treatment with Other Professionals

- ▶ Collaborative process varies, according to employment setting (e.g., team vs. individual decisions regarding client)
- ▶ Before making referral to mental health provider, call to verify:
 - ▶ Acceptance/comfort with this diagnosis, including
 - ▶ Age of clients and population served.
 - ▶ If client's insurance is accepted.
- ▶ Throughout treatment, the speech language pathologist should maintain communication with the mental health provider.
- ▶ Throughout treatment, the speech language pathologist should maintain communication with teachers and school personnel.
- ▶ If family relocates, SLP should investigate treatment options in new location to aid the family's continued receipt of service.

Evidence-Based Interventions for the SLP

- ▶ ASHA Website

https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589942812§ion=Treatment#SLP_Treatment_Options_and_Techniques

- ▶ Social Communication Anxiety Treatment, S-CAT (Klein, Armstrong, Skira, & Gordon, 2017)

https://www.researchgate.net/publication/297584864_Social_Communication_Anxiety_Treatment_S-CAT_for_children_and_families_with_selective_mutism_A_pilot_study

- ▶ Journal of Psychiatry and Psychiatric Disorders (mentions video self-modeling & role playing)

<http://www.jpsychiatrypsychiatricdisord.com/articles/selective-mutism-interventions-what-works.html>

Client Profiles & Activities

- ▶ Client M, female age 6: Two languages used at home; Military family with frequent moves; Enrolled in a preschool program; Would not eat at school; Would not eat at home if family friends or extended relatives were visiting; Not evaluated by mental health professional prior to SL evaluation.
- Evaluation: Coached mother on how to present items and left the room to observe interaction (receptive & expressive language, speech sound assessment); Observed pragmatics, voice, fluency from monitor; Periodically re-entered room to give mother instructions.
- Treatment: Systematic desensitization; Exposure-based practice. Activities included nonverbal turn-taking; AAC pictures for exchange; whispering to doll; Talking Tom app; Ultimately began talking with clinician in session but became silent after leaving therapy room; became silent when another person entered the room.

Client Profiles & Activities

- ▶ Client M, female age 6: Child received speech-language evaluation with suspicion of selective mutism.
- ▶ Evaluation: Poor eye contact with student clinician and supervision clinician throughout a 2-hour evaluation; Did not speak at all during 2-hour time frame (to clinicians or parents, possibly was aware that clinicians could see/hear via the observation system if she spoke to parents); Responded to test items to enable completion of a receptive vocabulary test (PPVT) and listening comprehension of the OWLS; Remained silent when expressive test items were presented and when language sample was attempted; Clinician used AAC Genie app to assess responsiveness to AAC, and client completed but remained silent
- ▶ Recommendations: Child attended evaluation only, as family's schedule did not permit enrollment in therapy; Parents were given information for mental health providers for assessment and for counseling; Family had no further contact with this clinician.

Client Profiles & Activities

- ▶ Client D, male age 7: military family; diagnosed with anxiety by mental health professional prior to SL evaluation; Would talk to same-aged peers if no adults were present/observing; Would whisper to just one teacher using a limited amount of verbal output but would not speak audibly; Would speak to no other adults than parents; Reported to have “meltdowns” over trivial matters
- Evaluation: Coached mother on how to present items and left the room to observe interaction (receptive & expressive language, speech sound assessment; AAC Genie); Observed pragmatics, voice, fluency from monitor; Periodically re-entered room to give mother instructions.
- Treatment: Systematic desensitization; Exposure-based practice. Activities included nonverbal turn-taking; AAC pictures for exchange; By 3rd session, began talking with clinician (adult) in session but became silent after leaving therapy room; Became silent when another adult (supervisor) entered the room; Ultimately referred to SLP provider in state where family relocated.

Client Profiles & Activities

- Client A, female age 9:
- Evaluation: Enrolled in counseling for anxiety for several months before the SM diagnosis was made; Reported as being silent all day at school; Was uncomfortable speaking with peers but sought treatment because was being left out of extracurricular activities; SL evaluation was relatively standard because complied with typical testing procedures.
- Treatment: systematic desensitization activities; explicit instruction in pragmatics; collaboration with school personnel; homework assignments with reporting back on how interactions went; Following two sessions, was able to have conversations with non-treating clinicians in facility and office personnel; responded well to treatment but insurance would not pay for services; Client and family felt comfortable continuing home program of practice (while continuing counseling for anxiety) when insurance stopped paying.

Client Profiles & Activities

- ▶ Client J, adolescent female: diagnosed with SM during preschool prior to this clinician's involvement in care; diagnosed with SM, speech sound disorder and other language (receptive and expressive) delays at age 3.
- ▶ Evaluation history: Details unknown; Within a year following the SM diagnosis, enrolled in counseling services;
- ▶ Treatment: systematic desensitization; exposure-based practice; explicit pragmatics instruction; video modeling and self-modeling; Teacher reported at age 11, did not initiate conversations with teachers or classmates but respond when prompted. Would not volunteer information in class, and would "avoid speaking, if possible"; Would speak "very briefly, talking only when necessary". Teachers described as "limited in words but adequate to convey meaning". The reluctance to speak did not significantly impede literacy skills, according to the teachers' reports; Nonverbal communication skills such as eye contact, facial expression, & gestures were appropriate within 2 years of treatment. By school age, was enrolled in special education; Later in treatment, accompanied on "field trips" to locations where she might potentially pursue employment

Client Profiles & Activities

- Client A. presented as a 18.5 year-old male with dx of ‘self-imposed mutism” per father. Speech changes noted when he was a toddler. Resulting in speech therapy since that time. At school, he used an AAC device and before graduating high school was said to use an SGD ‘with a keyboard style device”
- Evaluation: Peabody Picture Vocabulary Test standard score of 84, A. used Dynawrite Text to Speech to respond verbally throughout the session. He described Western Aphasia Battery ‘picnic’ picture using complete grammatically correct sentences; however, we noted simple grammar without adjectives or adverbs.). A’s vocational goal for life was to be a dishwasher.
- Diagnostic therapy- Recommended an AAC device (the Dynawrite) eventually. Father called SLP during the device loan period to report he had had his first – ever- conversation with his son. Initial objectives which were related to Selective mutism included:
 - A. will greet and initiate conversation
 - A. will ask & answer questions and express opinions

Client Profiles & Activities

- Client A: a 6-year-old female, was referred by her doctor with the diagnosis of selective mutism. She was home schooled at the time of the evaluation. Clinicians called the parents before the evaluation to ask them to bring in A's favorite toys, books to the evaluation. The evaluation was begun by playing with these toys until A. began speaking freely.
- Evaluation: language testing showed pragmatic deficits only. Speech testing showed a standard score of 71 and a percentile rank of 5. Clinicians noted an overall decreased intelligibility and that her rate of speech was rapid.
- Recommendations: This family had travelled 2 hours to this evaluation so names of speech language pathologists near their home were provided including treatment goals and a description of recommended plan : work to desensitize through stimulus fading, shaping, self modeling technique(watching videos of herself)

Client Profiles & Activities

- ▶ S. is a 14-year-old female, referred with a diagnosis of suspected selective. S. was able to communicate with others, but she was less comfortable doing so. In particular, she was most comfortable with family and adults but not with peers. S was homeschooled at the time of this evaluation but participates in her church choir.
- ▶ Evaluation: Language testing showed pragmatic deficits only. Speech assessment showed interdentalization of “ch”, “sh”, “dg/j” resulting in a standard score of 40 with a percentile rank of <.1. An overbite was also noted.
- ▶ Recommendation: Mental health referral was made with 2 names provided. In addition a referral to an orthodontist regarding the overbite was made. Speech objectives included demonstration of specific pragmatic skills (eye contact, facial expressions, topic maintenance, turn-taking) appropriate for each scenario which were drawn from typical routines. Desensitization activities were also recommended. S. made excellent progress in therapy tasks and in the community (part of therapy) but we did not have an opportunity to work with peers.



Client Profiles & Activities

- ▶ S a 5-year-old male was referred because, although he is talking at home, he is not talking in other environments. He was talking and developing normally until the previous summer when he was moved to another classroom and his teacher he had had for several years moved to another classroom.
- ▶ Evaluation: S. Was non-verbal during this evaluation. He used his mother or father's hands to point to pictures on the Peabody Picture Vocabulary Test. He earned a Standard score of 139. Attempts to use other assessments were not successful even if clinician left the room so that he was alone with his parents.
- ▶ Recommendations: Speech therapy to address expand use of expressive language including use of gestures, non-voiced sounds, and use of augmentative alternative therapy. A hierarchy of activities employing systematic desensitization. A referral to 2 mental health practitioners was also made.

Client Activities: Sample Defocused Communication Lesson Plan

Predetermined treatment modules reflecting increasingly difficult speaking levels to be obtained in the preschool/school setting from the baseline level of zero at T1; Does not speak to adults (as defined by the diagnosis of SM in the sample study)

Stage of Intervention

Description of the goal to be obtained in each speaking level

I

Speaks to the therapist (T) in a separate room with parent (P) present

II

Speaks to T in a separate room without P present

III

Speaks to one teacher/other adult in a separate room with T present

IV

Speaks to other teachers/adults (and children) in a separate room with T present

V

Speaks to teachers (and children) in some settings without T present (speaks to some, but not all adults and/or in some groups in the classroom, but not in all larger settings, such as full class)

VI

Speaks to teachers and children in all settings without T present (normal speech, indistinguishable from other children)

Oerbeck, B., Stein, M.B., Wentzel-Larsen, T., Langsrud, O/. & Kristensen, H. (2014). A randomised controlled trial of a home and school-based intervention for selective mutism – defocused communication and behavioural techniques. *Child and Adolescent Mental Health*, 19(3), 192-198.

References & Resources

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<https://selectivemutismcenter.org/wp-content/uploads/2017/03/Why-Testing-Expressive-Language-in-Children-with-Selective-Mutism.pdf>

- ▶ Selective Mutism Treatment: A Guide For Speech Therapists

<https://www.speechandlanguagekids.com/selective-mutism-treatment-a-guide-for-speech-therapists/>

- ▶ Social Communication Anxiety Treatment: Klein, E. R., Armstrong, S. L., Skira, K., & Gordon, J. (2017). Social communication anxiety treatment (S-CAT) for children and families with selective mutism: A pilot study. *Clinical child psychology and psychiatry*, 22(1), 90-108.

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- ▶ Selective Mutism, an Integrated Approach, Robert Shum

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- ▶ Selective Mutism Learning University

<http://selectivemutismlearning.org/selective-mutism-101/>

- ▶ Selective Mutism in Elementary School

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<http://www.speechscience.org/16-schoolbased-issues/2017/7/30/selective-mutism-the-role-of-speech-language-pathologists>

- ▶ Selective Mutism Treatment: A Guide For Speech Therapists

<https://www.speechandlanguagekids.com/selective-mutism-treatment-a-guide-for-speech-therapists/>

- ▶ Selective Mutism: A Three-Tiered Approach to Prevention & Intervention

<https://files.eric.ed.gov/fulltext/EJ934706.pdf>

- ▶ Selective Mutism Handout (includes titles of books that can be shared with individual with SM)

<https://www.sbbh.pitt.edu/files/pdf/Selective%20Mutism%20Handout.pdf>

References & Resources

- ▶ Selective Mutism Questionnaire

Authors: (Bergman, Keller, Placentini & Bergman, 2008)

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<http://iacapap.org/wp-content/uploads/F.5-MUTISM-2016.pdf>

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<https://onlinelibrary.wiley.com/doi/full/10.1111/camh.12045>



THANK YOU!

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