



Using a Counseling Approach When Working with Children with Selective Mutism

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Speech-language pathologists are uniquely prepared to counsel individuals who are anxious about talking and communicating. While we are known for our expertise in language facilitation, our understanding of communication extends beyond surface level linguistics into the rich inner world of beliefs and emotions and the complex outer world of speaking demands. We appreciate how perceptions, desires and feelings shape each communication act within a social context and are adept at describing these factors when we examine how an individual talks (or doesn't).

If a child does not respond in class, we take an open stance, and look at the complex variables involved. We observe the child in important classroom and playground speaking contexts and with different partners. We describe the full compliment of speaking opportunities and speaking demands that encase the child's verbal and non-verbal abilities. We listen and clarify when interviewing the child's parents and teachers. We manipulate aspects of the contexts so that we can find out how a child might respond to a specific intervention strategy. As we carefully analyze and interpret our data, we draw a conclusion about why we think the child is not talking and design an intervention plan that will involve changes in beliefs, perceptions, and emotions as well as observable behaviors. Many speech-language pathologists are masters at using counseling skills to problem-solve around communication issues and, as we will see later, this kind of experience is essential to the development of a credible intervention plan for individuals diagnosed with selective mutism.

What is Selective Mutism?

The first article on selective mutism in an American pediatric journal appeared in 1999 (Joseph, 1999). Thanks largely to prompting by the selective mutism community of families and professionals such as Selective Mutism Group-Childhood Anxiety Network (SMG-CAN), selective mutism is becoming a serious area of research in the United States, although it remains an understudied area (A quick check of PubMed showed 857 articles in selective mutism, compared to 2,682 for stuttering, 8,838 for autism and 9,274 for aphasia). Most mental health professionals now agree that selective mutism is

an anxiety disorder characterized in childhood by an inability to speak and communicate effectively in select social situations (Anstendig, 1999; Manassis, Fung, Tannock, Sloman, Fiksenbaum & McInnes, 2003; SMG-CAN). From this perspective, the core of selective mutism is debilitating fear, a fear that goes well beyond what a timid or shy speaker might experience and reaches to the anticipation of speaking in a social situation. These children simply find themselves unable to talk in some situations. Professionals who specialize in selective mutism believe the mutism is an attempt to avoid anxious feelings brought on by the expectancy to talk. Adults with selective mutism tell us just how painful this loss of speech is for the child.

What makes this disorder puzzling is that the child with selective mutism is often able to speak and communicate effectively when feeling secure and relaxed. This observation may lead to the conclusion that the child is behaving willfully and that mutism is the child's attempt to gain control over the environment. Uninformed, but generally well-meaning, proponents of this point of view may negatively reinforce or punish the child to alter the speaking behavior (SMG-CAN). While there is some disagreement among researchers about the degree to which social anxiety plays a role in the genesis of selective mutism, the majority of experts warn against trying to force a child to speak (Yeganeh, Beidel, Turner, Pina, & Silverman, 2003; Gordon, 2001). Such a course of action is likely to increase the child's anxiety and the adult's frustration. If the adult persists, the child may develop oppositional behavior as a reaction to the constant pressure to speak. The preferred intervention approach is a carefully constructed behavioral plan that works on reducing anxiety while building the child's ability to handle it (SMG-CAN; Rye & Ullman, 1999). Pharmacotherapy is generally not the first choice of treatment but may be included later (Kumpulainen, 2002).

Children with selective mutism show fear in different ways. Some children are completely mute in all social situations while others may whisper or speak in select settings. Fear may rob some children of expression and action leaving them emotionless and frozen in place while other children, though unable to talk, look completely natural and comfortable in the social context. Most children experience some degree of social isolation, although a small percentage of children

seem easy with social engagement.

Most children with selective mutism have a genetic disposition to anxiety. Common signs that often accompany selective mutism include extreme shyness from infancy, separation anxiety, frequent tantruming and crying, moodiness, inflexibility, and eating, toileting and sleep problems. Children with selective mutism tend toward severely inhibited temperament. Some researchers postulate a decreased threshold of excitability in the amygdala. In response to danger, the amygdala sets off a series of reactions designed to protect the individual. The danger signals for an individual with selective mutism are common daily social situations and the protective response is mutism (SMG-CAN).

Other factors and conditions may coexist with selective mutism including second language acquisition, sensory processing dysfunction and/or language impairment. It may be that the added stress of acquiring a second language or coping with a sensory or language impairment increases the individual's overall anxiety level (Shipon-Blum). The literature on language disorders is preliminary and suggests that some children with selective mutism may have a subtle language disorder (Gray, Jordan, Ziegler, & Livingston, 2002; Manassis, Fung, Tannock, Sloman, Fiksenbaum, & McInnes A. 2003). In one study, 7 children with selective mutism produced significantly shorter narratives than children with social phobia despite normal nonverbal cognitive and receptive language abilities (McInnes, Fung, Manassis, Fiksenbaum, Tannock, 2004). In another Australian study, 4 out of 5 children with selective mutism had concomitant language deficits (Cleator & Hand, 2001). The Selective-Mutism Group Childhood Anxiety Network (SMG-CAN) and American Speech-Language-Hearing Association estimate that 20-30% of children with selective mutism are language compromised.

Prevalence, Onset and Course of Selective Mutism

Once thought to be a rare disorder, a recent study showed that selective mutism affected 7.1/1000 elementary school children (Bergman, Piacentini & McCracken 2002). It appears to affect females more than males (Bergman, Piacentini & McCracken, 2002).

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Selective mutism is usually first identified when a child enters school, although onset occurs before the age of five. Many authors stress the importance of intervening early before mutism becomes a conditioned behavior that is resistant to change. The goal is to help children with selective mutism develop beliefs, attitudes and strategies that will allow them to cope with, and, perhaps, overcome, the anxiety about speaking. If left untreated, the situation is likely to worsen. Studies of adults with selective mutism who did not get professional help in childhood report depression, social isolation, poor self-esteem, low confidence, underachievement academically and in the work place, self-medication with drugs and alcohol and suicidal thoughts (Remschmidt, Poller, Herpertz-Dahlmann, Hennighausen & Gutenbrunner, 200; SMG-CAN). The good news is that intervention works. Children who get professional help early on generally improve, although outcomes depend on how entrenched and generalized the mutism is at the time of intervention.

Intervention and the Speech-Language Pathologist

So what can a speech-language pathologist do to help these individuals learn how to speak without fear? According to Dr. Shipon-Blum, CEO and Executive Medical Director of SMG-CAN and an internationally renowned expert on selective mutism, there is much that we can and should do. She views the speech-language pathologist as a natural team leader and a professional who is ideal to coordinate both assessment and intervention. For Dr. Shipon-Blum, the mutism is not about speaking, it is about the child's inability to communicate and engage in social interactions. The child is overwhelmed in a social context and simply shuts down. Although the underlying causes are generally complex and subtle, Dr. Shipon-Blum stresses that the causes for the initial shut down must be uncovered during a thorough evaluation in order to properly deal with the anxiety that drives the mutism. She believes that the speech-language pathologist has a specialized ability to describe and analyze communication contexts. This permits the team to get at the core of selective mutism and design an effective intervention program that includes desensitization to anxiety-producing social settings. Causes vary from child to child and sometimes several co-occur within the same child. Like most experts in the area of selective mutism, Dr. Shipon-Blum agrees that the common causes are a temperament prone to anxiety, sensory processing issues, a speech and language impairment or even bilingualism. In her experience, some adults do not appreciate that silence is normal when first learning a second language (the silent period) and may, wrongfully, put tremendous pressure on the child to speak. Consequently, the child becomes extremely conscious and anxious about speaking which

leads to a phobic reaction. When working with children who are selectively mute, Dr. Shipon-Blum strongly recommends that we access the resources that SMG~CAN makes available to parents, treatment professionals and educators at www.selectivemutism.org.

Counseling Goals and Methods

A primary counseling goal is to change the negative perceptions around communication that reinforce the child's self-concept as one who cannot speak. We work with parents, teachers, siblings and classmates to create an environment that assures the child that, "You are capable. You have interesting things to say and are fun to be around." We help the child with selective mutism take on a new self-concept, one that empowers him or her to deal with the fear and anxiety inherent in the social situation. How do we do this? We carefully apply our counseling skills to help the adults and the child identify their faulty beliefs, develop an action plan and then try on new ways of thinking and acting in specific situations. As we counsel the individuals to make these changes, we may need to script new ways of talking, problem solve and role-play new ways of interacting and perhaps make a contractual commitment to implement the changes. To illustrate these ideas, I add examples in the following sections that summarize the work that I did with a child in elementary school.

Susan, who was identified with selective mutism at the end of kindergarten, was in Ms. Brown's first grade class. Susan never spoke in the classroom. I observed that the students in Ms. Brown class talked for Susan. As one child explained, "Susan can't talk." In their tender, but misguided, attempts to protect Susan, her classmates were actually helping to habitualize her belief that she couldn't talk in class. After consultation with Ms. Brown, she began to systematically change the classroom culture. She carefully monitored how she talked about "talking." At first, she needed to script how she spoke to ensure that what she said empowered the class to believe that they were all effective communicators, that talking was a powerful tool for learning and that chatting with each other was a mark of friendship. She made classroom charts that highlighted the joys of talking and encouraged students to make positive comments about talking. Next, she found affirmative ways to prevent the children from talking for Susan and from making pointed comments about her mutism. Finally, she made sure that she took every opportunity to let Susan know that she viewed her as a competent student. She did all of these modifications carefully to avoid the impression that she was applying more speaking pressure. Ms.

Brown subtly and gradually changed the way the class viewed Susan and the way Susan viewed herself.

Another important counseling goal is to help parents and teachers recognize the need to make contextual and instructional modifications that will create opportunities for safe, relaxed speaking. From our observations and interviews, we can help the teacher construct a communication hierarchy that ranks speaking situations on a continuum from low to high threat. This hierarchy must reflect the world as the child with selective mutism views it, so we also try to work in partnership with the child to develop the ranking. Classroom teachers find the hierarchy an enormously valuable tool because it enables them to critically analyze the speaking demands in the classroom and to make sound judgments about what the child can and cannot do in each situation. Once a teacher knows what to expect of the child with selective mutism, he or she can provide the necessary level of support so that the child can successfully take risks.

I noticed that Susan and a classmate, Tiffany, spent time together on the playground at recess. After interviewing Tiffany, I discovered that Susan occasionally whispered to her using one or two words. From this information, Ms. Brown and I arranged for Susan and Tiffany to spend more one on one time away from the group in the classroom. We encouraged Susan and Tiffany to gradually expand the quality of their friendship. In a few days, Susan was whispering to Tiffany in the classroom. Together Ms. Brown and I worked out a systematic desensitization plan for the classroom and playground that gradually added communication demands to low threat situations while giving careful support.

The final essential counseling goal is to directly support the child as he or she begins to find communicating rewarding and pleasurable. This assistance takes many forms. From the initial evaluation results, the team determines the child's degree of impairment and establishes an entry point for intervention. Sometimes the speech-language pathologist works directly with the child during individual sessions. We might begin with no or low verbal expectations in a child-directed play format in order to earn the trust that is essential for risk taking. Eventually, once the child is ready to talk to us, we will want to move toward open discussions about speaking fears, taking risk and learning specific coping strategies. At other times, we work in small groups or with the entire classroom so that we can exploit natural opportunities for social interactions. These are ideal formats for helping

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children with selective mutism acquire any social strategies that they might be lacking. Whatever the setting, we are constantly coaching and encouraging the child to take reasonable communication risks at carefully selected moments during which we pay close attention to the child's degree of comfort in communication. Helping the child with selective mutism feel safe when communicating is crucial to enabling them to feel empowered during the situation.

During my first individual session with Susan, I quietly played with dolls and a dollhouse. What began as parallel play quickly evolved into non-verbal cooperative play. Susan became animated and actively engaged (without words) when she realized there would be no pressure to talk. During the second session, I began talking for her doll. Again there was no expectation that Susan would respond. By the end of the session, Susan softly said a few words for her doll. During subsequent sessions, as the play continued and the relationship developed, I began to make comments to Susan about what the dolls were thinking or doing. By this time, Susan knew that she was free to respond or remain quiet. Spontaneously, Susan began to comment and a face-to-face communication about the play slowly emerged. I made no overt requirements for Susan to talk. Instead, I allowed the authenticity of the context and the trusting relationship that had developed sweep Susan along toward verbal communication. Eventually, Susan began talking to me about her thoughts and feelings related to communication. We collaborated to find strategies that she could use to help her deal with her fears about talking in the classroom.

Conclusion

For a Speech-Language Pathologist, there is no greater thrill than the one we get when we help an individual cut off from communication find his or her unique voice. Working with a child who is identified with selective mutism is rife with such opportunities. Speech-language pathologists are better able than most other professionals to support children with selective mutism because we understand the complex psychological and behavioral dynamics required

to change how individuals communicate. We also know how to apply subtle counseling strategies to ensure that this change occurs. By using these counseling strategies, we can anchor the intervention in the psychological and emotional roots of the problem. ♦

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