RESEARCH-BASED TREATMENTS FOUND EFFECTIVE FOR SELECTIVE MUTISM


Treatment for Selective Mutism can include psychotherapy and medication to address the anxiety that underlies the person’s inability to speak in certain situations. Some children with Selective Mutism also benefit from speech-language therapy, occupational therapy, sensory-integration therapy, and other interventions that may be recommended by the main treatment provider(s).

In psychotherapy, a psychologist or other professional will use some of the following approaches, depending on the individual child:

**Behavioral and Cognitive-behavioral (CBT) strategies** are the most widely supported psychological treatment for Selective Mutism.

**Behavioral strategies:** This refers to coming up with a step-by-step plan where the child gradually does more and more difficult speaking-type behaviors, as well as coming up with a system of positive reinforcement whenever the child is able to accomplish those behaviors.

There are several behavioral strategies. They are most effective to support the child to make and maintain gains in speaking when they are used together:

- **contingency management** involves positive reinforcement of (or rewarding for) verbal behavior with initial reinforcement of nonverbal communication like pointing and whispering

- **shaping** reinforcement is provided for approximations of the target verbal behaviors (e.g., mouthing words, whispering, talking on the telephone) and later for normal speech. A reinforcement menu (what types of rewards the child wants to earn and for what behaviors) is first developed in collaboration with the child.

- **stimulus fading** interventions build on the success of contingency management and shaping by gradually increasing the number of people and places in which speech is rewarded. For example, the child may first be rewarded for speaking to a classmate to whom s/he already speaks outside of school. Gradually, other students are introduced into the group until the child is able to speak in the presence of a large group of peers. Stimulus fading can also be used in problematic situations that
occur outside of school (e.g., talking to grandparents, ordering in fast food restaurants).

**Systematic desensitization** traditionally involves the use of relaxation skills along with gradual exposure to successively more anxiety-provoking situations. In this type of intervention a hierarchy of feared speaking events is constructed and therapy consists of a series of imaginal and in vivo (real-life) exposures to feared situations.

**Social skills training** may also be used to reduce anxiety and facilitate speech with peers and involves learning what to say to initiate conversations, how to take turns, making eye contact, and learning how to understand another person’s nonverbal behavior.

**Self-modeling** involves making video and/or audiotapes that have been edited to depict the child speaking in settings in which he or she has previously remained mute. The tapes are played repeatedly throughout the intervention, with the expectation that the child will become accustomed to hearing him- or herself speaking in these settings and will begin to believe in his or her ability to do so.

**Cognitive strategies:** This involves identifying anxious thoughts that contribute to the mute behavior. Introducing cognitive strategies is most useful for children age 7 and older, when they have developed the ability to become aware of their thoughts. Techniques include recognizing body symptoms of anxiety, identifying and challenging maladaptive beliefs, and developing a coping plan to deal with distress. For example, many selectively mute children have anxious thoughts or worries that people will make fun of their voice or what they want to say. Cognitive therapy teaches the child to understand that those thoughts are the product of worry (and are not real threats) and to coach themselves by telling themselves positive thoughts instead. Cognitive strategies should be added to behavioral strategies at a point in time determined by the treatment provider.

Other therapies commonly used alongside the behavioral or cognitive-behavioral treatment above, while not necessarily researched or supported by research as yielding gains in children with SM, are aimed at increasing the child’s self-esteem to strengthen the child emotionally by reinforcing areas of competence, belonging and acceptance as he/she completes the difficult work involved in these behavioral and cognitive-behavioral therapies. These may include learning new skills and/or encouraging participating in sports, music, arts, etc.

**Medication**
A medical doctor (psychiatrist, pediatrician) can prescribe medications that address the anxiety that underlies the child’s inability to speak in certain situations. Medications are most effective when combined with behavioral and/or other psychological strategies above, especially to help the child maintain gains in communication over time. In particular, the SSRI (selective serotonin reuptake inhibitors) have the most evidence for being useful in youth with anxiety conditions.
Speech-Language Therapy

The following is excerpted from *Speech-Language Therapy and Selective Mutism* Contributed by: Evelyn R. Klein, PhD, CCC-SLP, BRS-CL and Sharon Lee Armstrong, PhD. For the full article see: http://www.selectivemutism.org/resources/library/Speech%20and%20Language%20Issues/Speech-Language%20Therapy%20and%20Selective%20Mutism/view

Speech-language pathologists (SLPs) may contribute to the treatment benefits of children with selective mutism (SM), as speech and/or language impairments can co-occur with SM. In addition, SLPs are trained in working with pragmatic language that is greatly impacted by children with SM. For these children, simultaneous treatment using both behavioral strategies to help children feel more comfortable to speak and linguistically-based activities to foster language development are recommended. SLPs often follow a behavioral approach of setting goals with gradual increases in expectations. For example, The Ritual Sound Approach® (RSA) that is a component of Social Communication Anxiety Treatment (S-CAT) by Dr. Shipon-Blum (2010) has had good success in helping children communicate with greater ease. The behavioral technique of *shaping* is used to help modify and shape specific phonemes into blended sounds that represent real words. This approach starts with voiceless speech sounds that require less vocal effort in that they don’t engage the vocal cords. Children feel air move in and out of their mouths as they breathe, blow, and cough. Thus, voiceless speech sounds such as /h/ (similar to breathing), /k/ (similar to a cough), /s/, /t/, /p/, etc. are used because they are less audible than vowels or voiced consonant sounds such as /z/, /d/, /b/, /g/, etc. This behaviorally-based treatment helps the child think of sound-making from a mechanical standpoint (e.g. put lips together lightly, build up air pressure in the mouth and puff out air to produce the sound of /p/).

SLPs may also use augmented self-modeling, a technique that has promise for reducing anxiety when speaking (Kehle, Bray, Byer-Alcorace, Theodore, & Kovac, 2011). The child watches videotaped segments of herself or himself during a positive verbal interchange (often at home) and then visually (through playback) carries the communicative interchange into another setting that is often more challenging. Using video software, the child can get a virtual glimpse into communicating successfully in a setting that causes heightened anxiety. In many instances coordinating voice and speech while thinking of what to say (linguistically) becomes difficult for children with SM due to anxiety. Therefore, non-speech tasks may be used to help the children gain control of voicing. Once vocal control in non-speech tasks is adequate then speech can be introduced slowly and systematically to allow for success. A typical progression is as follows:

1. Communicate by pointing, gesturing, or nodding (use games, toys, and age-appropriate projects)
2. Communicate by drawing or writing (use games requiring these modalities)
3. Talk through a recording device that is played when out of the room and then when in the room (as comfort increases)
4. Talk to another person who speaks for the child (in front of others with increasing distance from the person’s ear)
5. Talk to others using sounds (may be blended to form words)
6. Talk to others using rehearsed or scripted language with and without visual prompts (develop charts to play guessing games – include phone as possible)
7. Talks spontaneously using words or phrases (including phone)
8. Talks spontaneously using sentences (including phone)

Children with SM who present with a language delay may benefit from treatment that includes basic vocabulary development, grammatical morpheme development, and work on sentence structure. For many children with SM, the goal will be to enhance social-pragmatic communication with work on enhancing descriptive language (vocabulary and describing), expository language (informing and explaining), narrative language (storytelling), and discourse for social communication (discussing and interacting).

SLPs may first work on nonverbal skills of social engagement and later include communication skills in joint activity routines. Speech articulation therapy may also be part of the treatment protocol for children who have speech production errors, either sound substitutions, distortions, omissions, or additions.

It should be noted that some children with SM believe they cannot speak in some settings and so they may not properly engage their respiration, voice, or articulation appropriately. Children with SM can get accustomed to not speaking and thereby assume the self-image of the child who does not talk (Omdal, 2007). This self-fulfilling prophecy is one that can persist without appropriate intervention. The earlier the intervention, the better!

