



SELECTIVE MUTISM
GROUP

CHILDHOOD ANXIETY
NETWORK

Selective Mutism Group~Childhood Anxiety Network Newsletter - Spring 2011

Greetings!

**WELCOME to the Spring 2011 Newsletter
of Selective Mutism Group - Childhood Anxiety Network!**

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Carmen's Camp

Innovative, intensive treatments for Selective Mutism are beginning to take the shape of summer camps. A project similar to Dr. Steven Kurtz's Brave Buddies project, mentioned in an earlier newsletter, is debuting in the Chicago area, and enrollment is open for August of 2011. Run by Dr. Carmen Lynas, the project is called Adventure Camp. The focus of Adventure Camp is to simulate a typical school day, and thereby prepare children with Selective Mutism to return to the school setting in the fall. Each child is paired up with a trained counselor prior to camp, and meets several times with that counselor to increase comfort and obtain speech. For the 1-week camp, children are assembled in a simulated classroom to participate, with the support of their assigned counselor, in the activities of the day, including calendar time, circle time, free play, snack time, and field trips to the park, library, ice cream shop. Each activity and field trip is designed to provide the children with the opportunity to practice "brave talking" and social interaction with peers, adult counselors, and novel adults in the public setting. For more information or to enroll, go to www.drcarmenlynas.com.

Journal Article Review:

Selective Mutism: A Review and Integration of the Last 15 Years

by Shannon Morgan-Gillard, Psy.D



The following is a review of the journal publication: Viana, A.G., Beidel, D.C., & Rabian, B. (2009). Selective mutism: A review and integration of the last 15 years. *Clinical Psychology Review*, 29, 57-67.

This article served to review and summarize a substantial amount of the existing literature on SM published during the prior 15 years. The authors noted that they excluded research published prior to 1992, written in foreign languages, and not published in peer-reviewed journals, as well as case studies. The article reported its purpose being to clarify what SM is (and is not) and what we can conclude about why it develops, including research, and treatment.

This article also considers problems resulting from encounters between people and the environment over time. Genetics, cognition (related to learning and memory), and interpersonal issues affect life circumstances and the course of SM.

In discussing the etiology of (or what causes) SM, the authors indicate that it is "complex and multidetermined." The authors note the lag time between onset of the disorder and time of referral for treatment, which can be one or more years because of the very nature of the disorder presenting itself outside the home when the child enters school. The article returns to a review of several vulnerabilities in a child's development that can create pathways to the development of SM. The authors indicate that "there is no single identified cause of SM" and determine that it may be the result of transactions among genetic and environmental influences. Because there are multiple theories about what brings about SM, there are likely multiple possible contributors or routes to its development.

The authors focus on genetic vulnerabilities, neurological/neurodevelopmental vulnerabilities, psychological vulnerabilities, and family and environmental vulnerabilities that present as pathways to the development of SM. They reviewed research comparing children with SM to various other groups of children, and noted limitations in some of the research.

In discussing genetic vulnerabilities, the authors note that studies of families of SM children do not have consistent results. Some studies show a family history of mental health issues while others do not. The article states that overall, in families with children who have SM, anxiety disorders, especially social anxiety, are often present. This type of anxiety in a family appears to predispose a child to develop SM.

The article discusses several neurological/neurodevelopmental vulnerabilities and determined that some may contribute to the development of SM. The authors reviewed research stating that language/communication disorders, a sign of neurodevelopmental delay, are found in some children with SM. Deficits in visual memory were found in some SM children. A third category of problems indicative of neurodevelopmental delay found possibly linked to SM was fine and gross motor problems and delays in socioemotional milestones. Finally, they cited support that auditory processing deficits are present in a subgroup of children who develop SM.

Psychological vulnerabilities include anxiety and/or acting-out disorders. The authors found significant evidence that SM is an anxiety disorder. They report that children with SM show internalizing symptoms in general, with anxiety in particular, and specifically social anxiety. Additional evidence was found in parent and teacher ratings of children with SM on anxiety, social distress, and larger categories of internalizing and externalizing behaviors. The review of research indicated that children with SM scored significantly higher on internalizing and withdrawal problems. By contrast to strong and unequivocal evidence of SM as an anxious internalizing disorder, the authors report finding mixed evidence for the presence of externalizing (or acting-out) symptoms, particularly oppositional symptoms, in children with SM. They note some research that supports a small proportion of children with SM who also have a disruptive disorder (specifically naming oppositional defiant disorder or attention-deficit/hyperactivity disorder), while other findings dispute such findings. They reference studies that interpret such data as perhaps indicating that children with SM who demonstrate some acting out and aggressive behaviors do

so in anxious or fearful response to a situation but do not present with a general pattern of defiant behavior. Finally, the article reports research findings of SM co-occurring or being associated with disorders characterized by delays in developmental milestones, such as in communication skills and elimination (e.g., bladder) control.

The article also discussed findings of research related to family and environmental variables. Authors For a very small proportion of children there may be a traumatic experience related to the onset of SM, and that there may be marital problems in some families with children with SM. Research on environmental factors of immigration and second language acquisition was reviewed and considered as contributors to developing SM. The processes attached to immigration aside from the language learning (e.g., acculturation, discrimination/ostracism), and how they interact in a child with or predisposed to SM, need consideration to aid our understanding of how SM can develop in this population.

In the remainder of the article the authors discuss appropriate assessment strategies to accurately diagnose Selective Mutism, and offered minimal attention (because of minimal valid literature) to treatments that are currently available and evidence of their relative effectiveness.

Regarding assessment, the authors recommend a multimodal and multi-trait assessment strategy as this follows from their findings that SM is a complex disorder that can be determined from any one or combination of etiological factors. The article first recommends including a clinical interview with parents, to understand symptom history and conditions where mutism occurs. Adjunctive to this may be a functional analysis to determine what might precede and reinforce or maintain the child's mutism. Second, it recommends a thorough developmental history of the child, in part for the purpose of differential diagnosis or determining whether the symptoms described are in fact best accounted for by Selective Mutism or some other or combination of other diagnoses. Third, authors recommend seeking teacher input as to the child's degree of inhibition, whether the child is more or less likely/able to talk in certain conditions or activities, and for input toward future treatment planning regarding peers the child is more comfortable with and effective strategies that may have been used. Fourth, the authors recommend to interview and observe the child directly to determine firsthand aspects and severity of the mutism and related impairments. Finally, the article advises conducting a speech and language assessment such as a nonverbal test of receptive language, and possible inclusion of audiotaping the child speaking in a comfortable setting and listening for speech problems, in order to appreciate potential deficits in these areas.

The article reports on what we know about treatments that are currently available for SM based on the minimal research literature to date on this topic. The authors note that there are weaknesses in the research methods of studies of treatment, which places limitations on what we can conclude from it. The authors report on three types of treatment interventions for SM: behavioral, cognitive-behavioral, and pharmacological (or medications). Taking into consideration what they observed about limitations to the validity of the research, the authors present findings that research shows behavioral interventions to be effective in increasing and maintaining speech. Several behavioral strategies and how they are used with SM are referenced and explained: contingency management, or giving positive reinforcement (a reward) for verbalizing; shaping, or first reinforcing the behaviors the child can do that are close to

communicative behavior and progressively reinforcing higher order behaviors until communication is in the form of speaking; stimulus fading, which is progressively increasing the number of people present when the child is speaking; systematic desensitization, or exposing the child to a progressive hierarchy of feared situations or people, resulting in diminished or extinguished experience of fear; and self-modeling, or audio/videotaping the child speaking in a comfortable setting and editing the tape to simulate the child speaking in a setting where s/he does not speak, and reviewing the tape with the child so he can imagine and "see" himself speaking. Next, the authors briefly discuss cognitive behavioral interventions (though not described therein, in brief these are interventions where a person examines his/her thoughts and challenges irrational thoughts that promote anxiety). Authors cite that this appears to be successful with SM, while they note that the cognitive portion is difficult for many clients with SM as they are young and therefore lack cognitive skills (such as awareness of their thoughts) necessary to fully leverage this treatment. Finally, the article discusses the use of Fluoxetine (generic name Prozac) as potentially effective according to the research reviewed. Authors include reference to its possible mechanism in treating SM of reducing arousal in social settings.

This review article concludes with a summary of findings from the authors' examination of 15 years of research. Their summary highlights that SM appears to result from complex interactions between an individual and the environment over time. The article references evidence of a familial-genetic predisposition for SM. It reports evidence through much of the literature of a significant association between SM and anxiety disorders in general and social anxiety in particular. There is evidence of a high rate of comorbidity of communication disorders with SM. There are findings that a group of children may develop SM in part because of learned familial interaction styles that reinforce avoidant behavior, and a different group of children develops SM in part due to a comorbid communication disorder. The authors suggest further research in several areas: to discern whether SM and social anxiety are distinct disorders or if SM is a type of social anxiety; aspects of the context or environment that lead to development of SM versus to the development of other anxiety disorders (for example, family dynamics, immigration status); the role of oppositionality in SM given the implications of assigning a treatment direction - whether guided by premise of a need to treat an anxiety disorder or an oppositional defiant disorder. Finally, the authors of the article identify a need for a systematic assessment of SM, research with large enough samples of subjects from which to draw valid conclusions, and research on the etiology of SM. The article concludes with two specific ideas for research that the authors find "promising." These are to investigate behaviorally inhibited children to determine what interactions or aspects of their environments with their genetic predispositions lead to the development of SM, and considering SM an avoidant behavior (not disorder) resulting from the various developmental pathways cited in the article.

This article review was written by Shannon Morgan-Gillard, Psy.D., a clinical psychologist and SMG-CAN Board member who treats children and adolescents with Selective Mutism and a range of other concerns.

Thinking About Expressive Language in Children with Selective Mutism

by Evelyn R. Klein, PhD, CCC-SLP



Children with selective mutism (SM) are unable to speak in certain settings but can speak in other settings where they feel comfortable. Due to the fact that SM is typically not diagnosed until the child enters school, speech and language abilities in the home are often overlooked. The discrepancy between these two language environments is worthy of consideration. Once in school, a different language environment emerges. Marvin & Cline (2010) found that teachers talk more about people, places, things, and events not in the immediate present. The topics tend to be more decontextualized than what parents talk about with children at home. In addition, during the early school years, talk among peers often includes more pretend play and fantasy than the context-bound language at home. Narrative skills also become a necessity and require the ability to talk about events and tell stories. For such tasks, talk about non-immediate decontextualized language is required. For children with SM, difficulty with more decontextualized language expression may make speaking an even more anxiety-provoking task.

Meaningful, audible speech requires the generation of thoughts or ideas using words to convey meaning. The dynamic flow of utterances between people in a form both understand involves language that is based on a set of rules that have meaning. Research supports the fact that more talking among family members is associated with enhanced language abilities in children. The more talking that is non-directive and conversational, for the sake of communicating, has been found to benefit language development (Hart & Risley, 1995).

Research from DeTemple (2001) reported two primary types of parent-child talk. There is the talk of the immediate here-and-now and the non-immediate talk that relates to more abstract knowledge and personal experiences. Non-immediate talk is more conversational and requires generalization and inferential skills. DeTemple found that the use of more immediate talk was associated with weaker language skills. However, non-immediate talk was positively associated with better vocabulary comprehension and use as well as story comprehension and enhanced literacy skills. In addition, narrative storytelling, describing, connecting cause-effect relationships, and providing explanations all support discourse skills. Weigel, Lowman, & Martin (2007) found that children benefited from enhanced language and literacy skills when shared storybook reading was used regularly and children were encouraged to help read the story, ask questions during the story reading, and relate the story to actual events in life.

While some children with SM may have an accompanying expressive language disorder, it is typically difficult to assess. Nevertheless, it is important to do so. Since children with SM more readily speak to their parents than to others, our team of researchers at the Selective Mutism Research Institute (SMRI) solicited the help of parents with standardized and norm-referenced tests. Using the Test of Narrative Language (TNL), parents asked their children questions from the testing protocol. Speech-language pathologists and psychologists then analyzed and scored the results for more than 60 children. They found that more than half the children had significant difficulty formulating language to tell a story to their parents (when no one else was around). The children did not appear anxious during this time and many sang, walked around the room, and spoke freely using a normal voice. However, they had difficulty with non-immediate decontextualized language tasks. Generating a story from a picture was a difficult task for many children. It is speculated that lack of exposure and experience with decontextualized language (including narrative language) can result in delayed language formulation. Children with SM may find it difficult to verbally communicate in situations requiring narration and conversation, most often at school. As language tasks become more challenging in situations outside the home, anxiety may increase because the linguistic load becomes more demanding. Over time, a child's lack of effective expressive language output (speaking) may lead to greater impairment with verbal expression and greater resistance to change.

The message is that children who cannot be adequately tested on expressive language tasks cannot be assumed to have normal language ability just because they talk at home or score within the normal range on language comprehension tasks. Both comprehension and expression are important to assess. Parents, when properly instructed, can help!

References:

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Weiger,, D.J., Lowman, J.L., & Martin, S.S. (2007). Language development in the years before school: A comparison of developmental assets in home and child care settings. *Early Child Development and Care*, 177, 719-734.

This article was written by Evelyn R. Klein, PhD, CCC-SLP, BRS-CL, a licensed, certified speech-language pathologist & licensed psychologist, an associate professor at La Salle University and on the Board of SMG-CAN.

Book Reviews:

"Helping Children with SM and Their Parents"; "Silence Is Not Golden"

Reviewed by Ruth Anan, PhD.



Dr. Christopher Kearney is a clinical child psychologist and professor at the University of Nevada Las Vegas. He specializes in the treatment of children with anxiety disorders, including selective mutism (SM). Two of Dr. Kearney's books were recently published by Oxford University Press in 2010.

Helping Children with Selective Mutism and Their Parents: A Guide for School-Based Professionals describes evidence-based treatment strategies that can be implemented by school staff in collaboration with parents.

Dr. Kearney uses many case examples to help the reader gain an understanding of the commonalities as well as differences that exist among children with this disorder. Initial chapters describe the importance of conducting a thorough assessment that examines symptoms surrounding a child's failure to speak and the response of others to the child's mutism. Helpful questionnaires and worksheets are included to facilitate initial assessment and monitor response to treatment.

Dr. Kearney explains the interconnection among behavioral, physiological, and cognitive components of anxiety and why treatment must focus on all three of these elements. Description of exposure-based practices, which address the behavioral component of anxiety, constitutes several chapters. Dr. Kearney describes how to develop an individualized exposure hierarchy, arranging a child's speaking goals in small sequential steps ranging from least to most anxiety-provoking. For example, an initial step may be for the child to whisper to his or her mother at home in the presence of the teacher and the final goal might be to speak directly to the teacher in class using a normal voice volume. Of course there are many unique, intermediary steps along the way. Dr. Kearney explains how to use many behavior analytic techniques such as shaping, prompting, stimulus fading, escape extinction, and contingency management to facilitate progress in exposure-based treatment.

To address the physiological component of anxiety, Dr. Kearney describes how to teach children to use breathing exercises and progressive muscle relaxation techniques. These interventions are then incorporated in exposure-based practice. To address the cognitive aspect of anxiety experienced by

children with SM, Dr. Kearney explains how to teach children to replace problematic or dysfunctional thoughts about speaking with more realistic beliefs.

Dr. Kearney devotes an entire chapter to designing treatment for selectively mute children who present with less anxiety, but exhibit a high degree of oppositional behavior. This chapter provides more detail regarding contingency management and ways to use rewards and disincentives to increase vocal speech and extinguish non-speech compensatory behaviors. A sample daily report form is included to efficiently convey to parents the level of compliance their child exhibits each school day. Another chapter focuses on treatment strategies for children with underlying speech and/or language deficits. Dr. Kearney's final chapter addresses ways to prevent relapse after treatment has been discontinued.

Dr. Kearney's second book, *Silence is Not Golden: Strategies for Helping the Shy Child*, does not focus exclusively on selective mutism, but it does include intervention techniques that can be helpful for this population of children, particularly those with less severe SM symptoms. This book is designed for parents, giving them strategies for identifying the form and function of their child's excessive shyness and offering them methods for enhancing their child's social participation. Dr. Kearney covers various etiological factors for excessive shyness such as behavioral inhibition, worrisome thoughts, and patterns of learning experiences. He then describes how symptoms can potentially worsen over time without treatment.

Silence is Not Golden addresses the behavioral, physiological and cognitive aspects of anxiety experienced by children with excessive shyness. As in Dr. Kearney's SM book described above, intervention modalities include: exposure-based practice sessions, relaxation techniques, and changing dysfunctional cognitions such as "no one likes to play with me" to more realistic beliefs. While in both books Dr. Kearney provides several chapters describing how to implement hierarchical steps of exposure-based treatment, in *Silence is Not Golden* he provides more detail about how to improve shy children's social skills, devoting an entire chapter to this topic.

There is considerable overlap in the content of these two books. Differences include the intended audience and the severity of symptoms addressed. *Helping Children with Selective Mutism* is written for school-based professionals treating moderate SM while *Silence is Golden* is designed for parents of children with excessive shyness who may also present with mild SM. I would recommend the former book for both school personnel and parents of children with mild or moderate SM while reserving the latter book for parents of extremely shy, but not selectively mute children. Both books provide a clear description of comprehensive, evidence-based intervention techniques that are effective for children with social anxiety.

Dr. Kearney's books were reviewed by Ruth Anan, PhD. Dr. Anan is a Licensed Psychologist and Board Certified Behavior Analyst who serves as the Director of the Early Childhood Program at William Beaumont Hospital's Center for Human Development. She provides individual and group therapy for children with selective mutism.

Expert Chat - Wednesday, May 18th, 9pm Eastern Time



Don't miss the 'Expert Chat' on Wednesday, May 18th, at 9 pm Eastern Time We are very pleased to announce that we are having another Expert Chat in the month of May. Our Expert is Dr. Kearney, Distinguished Professor of Psychology at UNLV. He is the Director of the UNLV Child School Refusal and Anxiety Disorders Clinic, and he is the Director of Clinical Training. Dr. Kearney has written extensively in the area of Childhood Anxiety, School Refusal, and he published a book on Selective Mutism last year. Dr. Kearney will certainly be a great Expert and Speaker, with his very rich background in academic, research as well as clinical experience. Please, join us in this very fruitful and informative activity that is a benefit to the members of the SMG. org. Vera Joffe, Ph.D.

ABC's and 123s: Preparation for the Next School Year



School is typically the most challenging setting for children with selective mutism (SM). In this workshop, Psychology Extern Brittany Leff discusses ways to help children with SM experience less anxiety and increase their participation and "brave talking" in school settings. You'll learn about the behavioral techniques used in the treatment of SM at the Child Mind Institute as well as exciting training opportunities for teachers. We encourage both parents and teachers of children with SM to attend this workshop. Check out - <http://www.selectivemutism.org/events/abcs-and-123s-preparation-for-the-next-school-year> The Child Mind Institute is streaming these workshops live to www.ustream.tv/channel/child-mind-institute so that interested families can watch and participate live, in real-time, from anywhere in the world!

SMG Annual Conference

Date: October 28, 2011 Time: 8:00 AM - 5:00 PM Place: New York City Check out - <http://www.selectivemutism.org/events/smg-annual-conference-1>

