Selective Mutism 101
Parent & Educator Workshop

CHILD MIND® INSTITUTE

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Child Mind Institute

Founded in 2009

The **only independent nonprofit** organization exclusively dedicated to transforming mental health care for children everywhere.

To help children reach their full potential we must:

- Develop more effective treatments for childhood psychiatric and learning disorders.
- Empower children, families and teachers with the scientifically sound information they need.
- Build the science of healthy brain development.

The Child Mind Institute does not accept funding from the pharmaceutical industry.

"The Child Mind Institute dares to imagine a world where no child suffers from mental illness."

-Brooke Garber Neidich, Chair, Child Mind Institute

Upcoming Events

For more information, please visit **childmind.org/events**

Building Brave Muscles: The Specific Behavioral Skills that Target Bravery - LIVESTREAM
Presented by Elianna Platt, MA, LMSW
Wednesday, November 16, 2016
6:15 PM – 7:30 PM EST

BRAVE BUDDIES - ONE DAY SESSION
Friday, December 16, 2016
9:00 AM – 2:00 PM EST
Location: Child Mind Institute

Climbing the Ladder: Practicing Brave Talking Skills - LIVESTREAM
Presented by Rachel Busman, PsyD
Wednesday, January 25, 2017
6:15 PM – 7:30 PM EST

WELCOME!

- This workshop is part of a series
- On site and live streamed
- Archived
- View in order
- Share with others
- Hear Our Voices in May

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Outline of Our Time Together

- Anxiety Overview
- What is Selective Mutism?
- Prevalence
- Debunk the Myths
- Nature vs. Nurture
- Assessment
- Treatment

ANXIETY OVERVIEW

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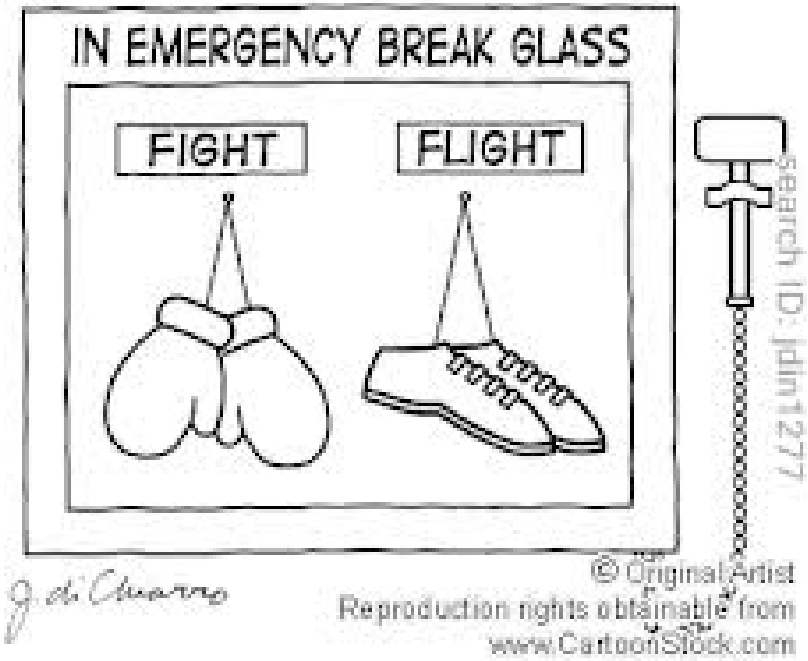
Fear: Typical or Atypical?

- Fear is a normal and adaptive system in the body that tells us when we are in danger
- Fear usually refers to an immediate threat
- This becomes a problem when the body tells us there is danger when there is no real danger
- Or, when we anticipate situations/stressors that go beyond what is reasonable fear

Fight or Flight



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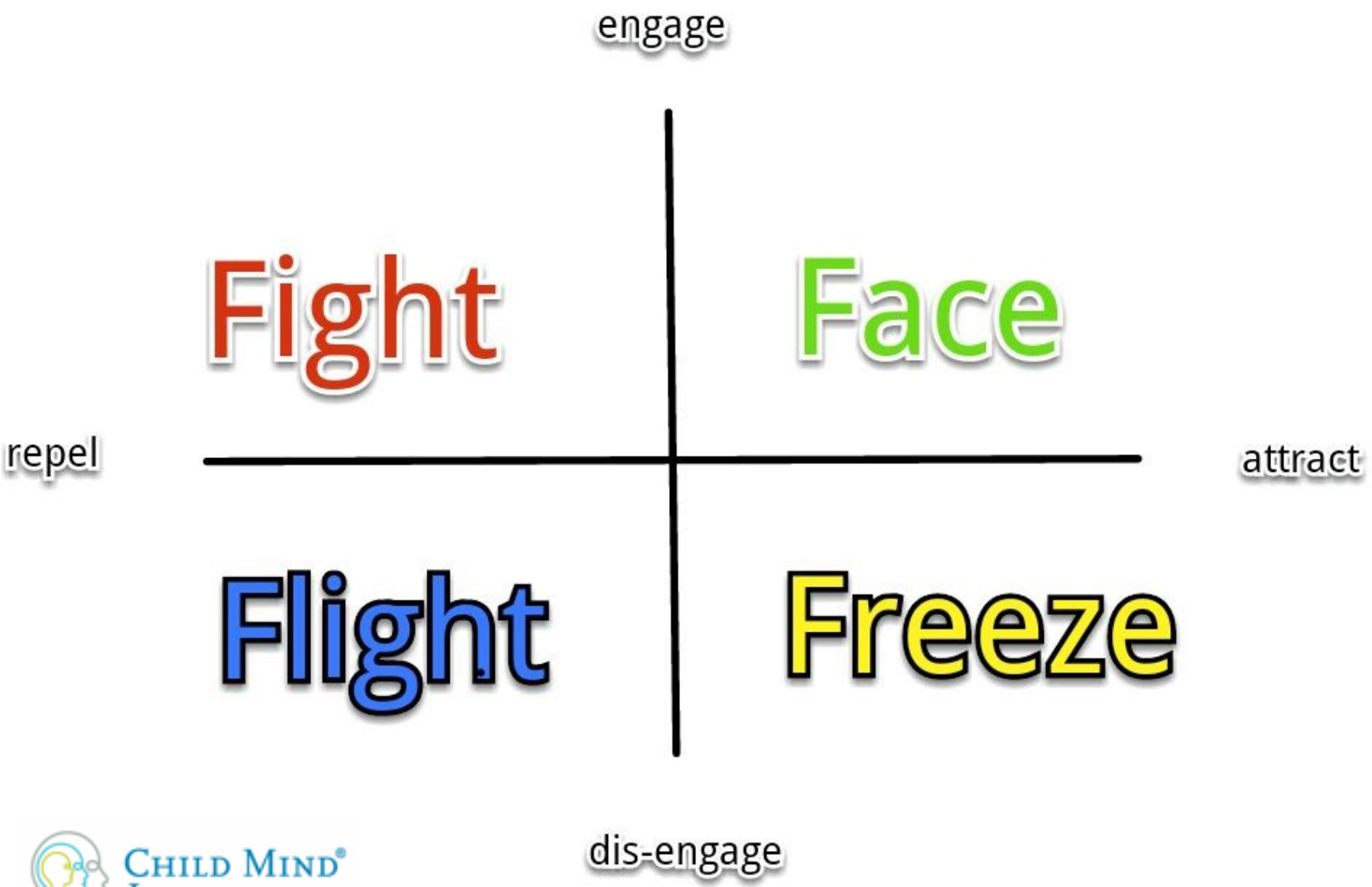

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When Does Anxiety become a Disorder?

- Frequency
- Duration
- Impairment: interferes with a child's development
- A child cannot do his/her **job**

‘The Fire Alarm’

Frequent False Alarms

and

Difficulty Resetting

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Facts About Anxiety Disorders

- 1 in 8 children have an anxiety disorder
- More than 40 million adults in the US have reported disabling anxiety that negatively impacts their lives
- Delay to seek treatment is more the norm than the exception (can be months or years)
- It is estimated that less than one third of youth with anxiety disorders seek treatment and even fewer receive evidence-based treatment
- Untreated anxiety disorders → host of negative outcomes

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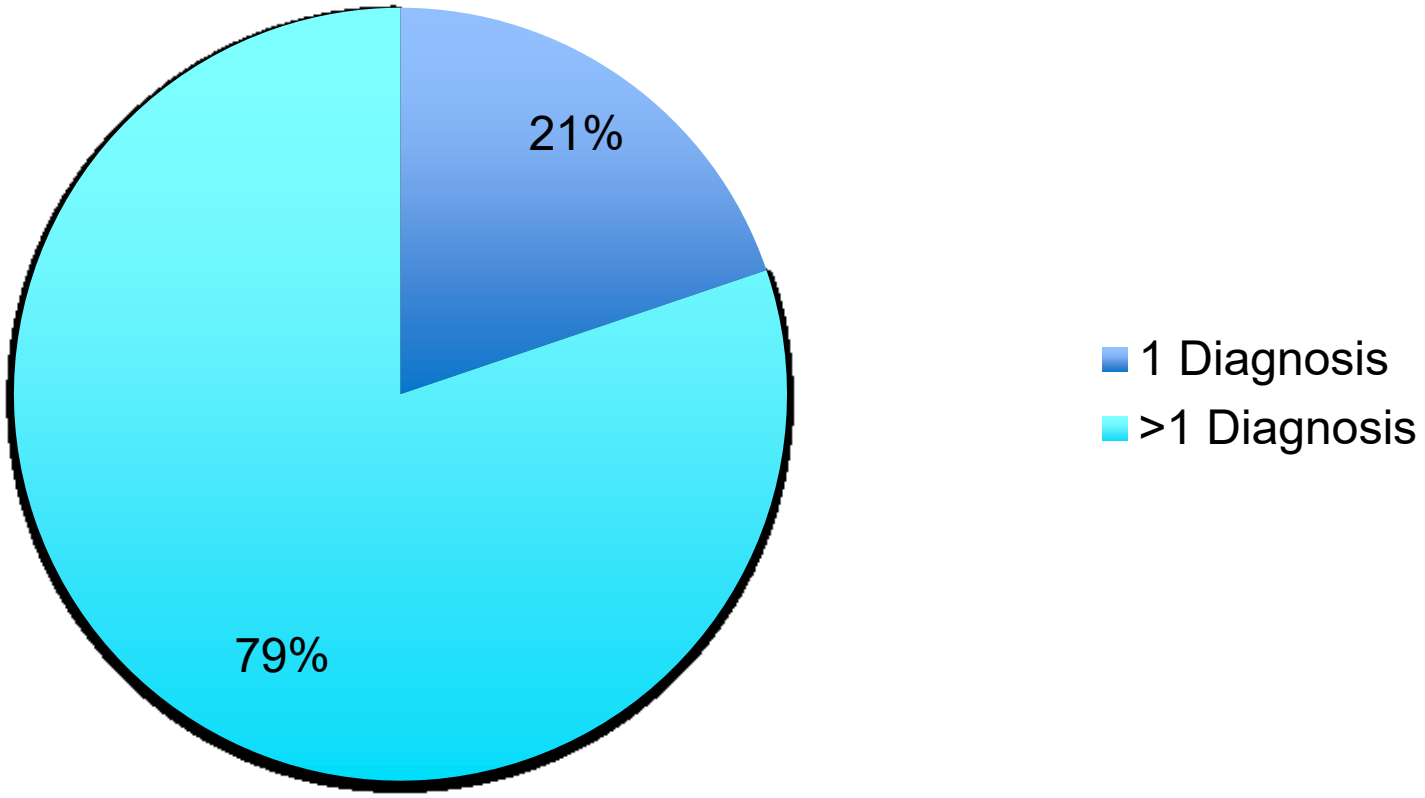
Comorbidities Among Child Anxiety Disorders



Kendall, Brady, & Verduin (JAACAP; 2001)

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Untreated Anxiety

- Diminished self-esteem
- Academic problems, including school refusal
- Poor social development
- Chronic mental health problems
- Substance abuse, self medication
- Depression

→ Bottom line: short-term and long-term negative consequences

The Good News

While anxiety disorders are the most diagnosed, they are also **highly treatable**,

especially when caught early*

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*early on in the course of illness and/or age

WHAT IS SELECTIVE MUTISM?

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What is Selective Mutism (SM)?

- Persistent failure to speak in specific social situations when speaking is expected (e.g. school, extra-curricular activities, play dates) but speaks fluently in other situations (e.g. home)
- Causes IMPAIRMENT; interferes with educational achievement or with social communication
- Not due to a communication disorder
- Not due to lack of knowledge or discomfort with the language
- Not diagnosed in first month of school

You Are Impaired When…

- You get on the wrong school bus and can't tell the driver
- You wet yourself when you need to go to bathroom and are afraid to ask for a pass
- You are sick and don't tell your teacher that you need to go to the nurse
- You know the answer and don't raise your hand
- You can't tell your friend, "I have that toy, too"
- You can't participate in plays, classroom activities, playdates
- You can't order food or answer a store clerk
- You can't talk to a grandparent or aunt

PREVALENCE

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Prevalence

- Research suggests between .7% to 2% in early elementary school
- Typically diagnosed around age 3
- One and a half, to two times more likely in girls than boys

Prevalence Statistics

- 7-8 year-olds 2% Finland (1998)
- 7-15 year-olds .18% Sweden (1997)
- 5-8 year-olds .71% California (2002)
- 1-2.6/1 female / male Garcia et al (2004)

Bergman et al., (2002)

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DEBUNK THE MYTHS

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Debunk The Myths

- Elective Mutism
- Selective Mutism = Social Phobia
- Trauma Related
- Child will “out grow” the behavior
- Shy
- Autism
- Cognitive Deficits
- Language Disorders

The Building Blocks of Speech & Language

- Speech & Language is the result of coordinated actions among several domains

Environment	Cognitive	Structures	Social-Emotional
Cultural factors External Interpersonal factors	Perception Discrimination Concept Formation	Structures Neuromuscular integrity Sensation	Interpersonal interactions Trust Pragmatics/ Language use

Communication Disorder

- A **communication disorder** is an impairment in the ability to receive, send, process, and comprehend concepts or verbal, nonverbal and graphic symbol systems (ASHA).
- Hearing, language, and/or speech
- May range in severity from mild to profound
- It may be developmental or acquired
- Individuals may demonstrate one or any combination of communication disorders
- A communication disorder may be primary or secondary

A Few Studies

(summarized by Klein et al, 2011)

- Cleator & Hand, 2001 found 4 of 5 children with SM had expressive language disorders
- Manassis et al, 2007 found 44 children with SM had poorer performance on linguistic measures compared to 28 children diagnosed with anxiety disorders and 19 controls
- Sharp et al, 2007 found that language related difficulties appear to be a significant risk factor for the development of SM

NATURE VS. NURTURE

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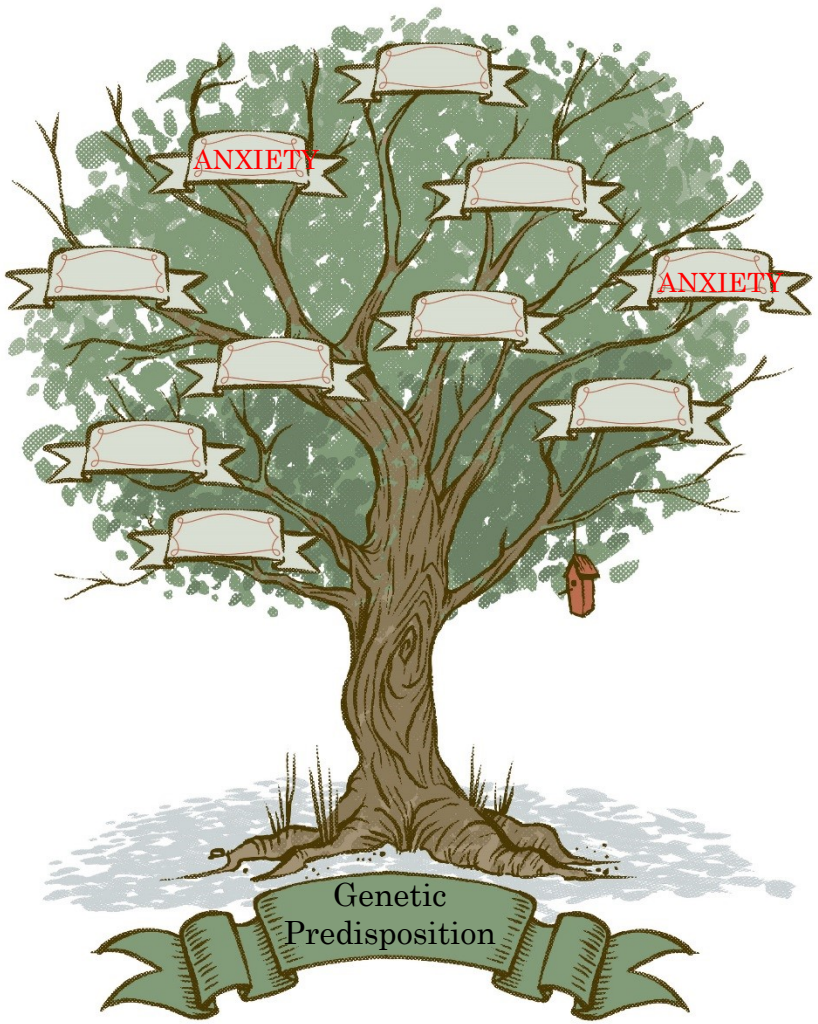
Current Conceptualization of Selective Mutism

Nature *and* Nurture

Nature



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Nurture

The Environment's
Role in Shaping the Inhibited Stance

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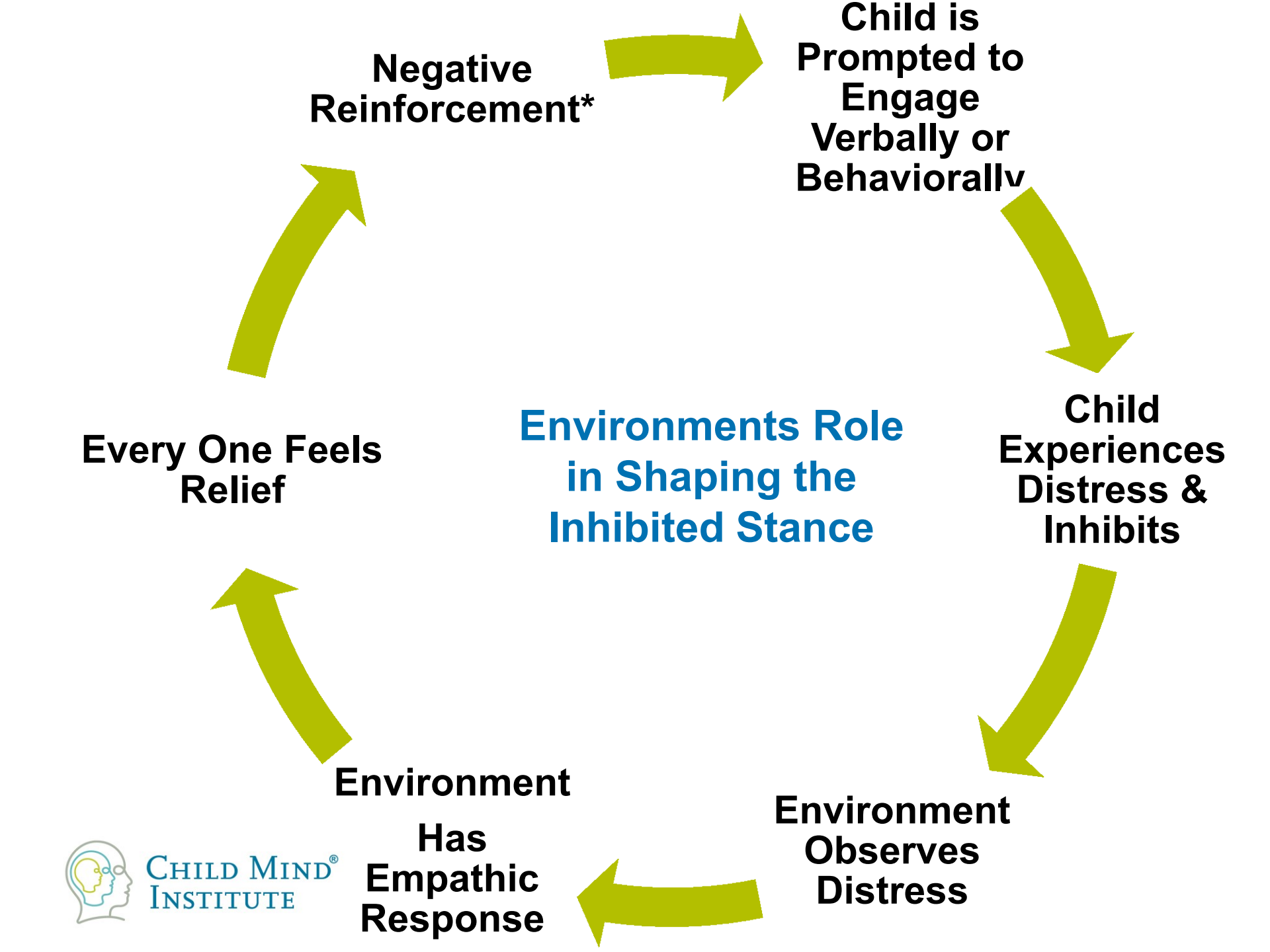

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Long Series of Negatively Reinforced Interactions
(A learned response)

Becomes Automatic

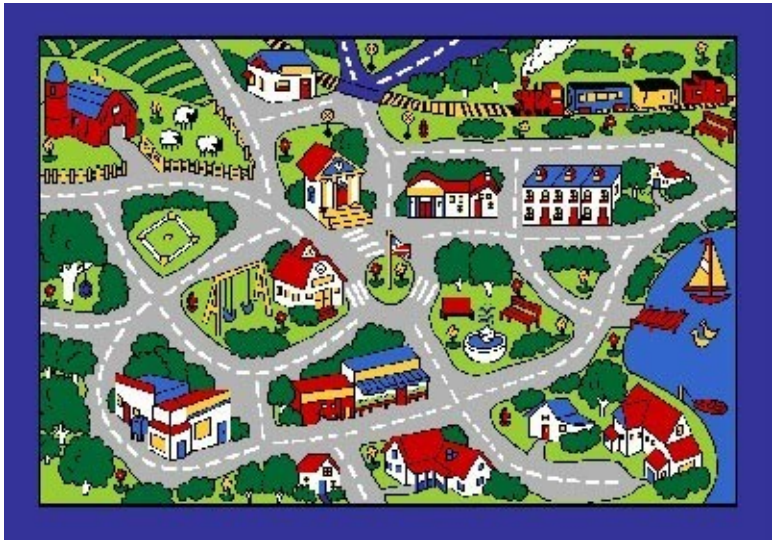
Rapid Fire on a Daily Basis

Disclaimer: Enabling is our natural instinct

When we see someone in distress it is our natural reaction to offer help

A Divided World

- Kids may divide the world into people, places or settings in which they walk
- Boundaries may be rigid or may be more fluid
- E.g.- entering school



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People, Places, and Activities

- Unique variations from child to child
- Treatment needs to be individualized to these variations
- Same goal and same approach, but different starting points and different size steps

The Contamination Effect
AKA Learning History

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A Diagnostic Evaluation and Talking Map Are the Starting Places

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ASSESSMENT

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Evaluation

- Clinical Interview(s): KSADS or ADIS
- Rating Scales: normed and objective
- SMBOT: observation of dyad
- Communication with school
- VIDEO SAMPLES
- Review of previous evaluations
- Differential diagnosis
  - Clear diagnosis and treatment plan

SMBOT

- SM Baseline Observation Task
- Based on the DPICS (Dyadic Parent Interaction Coding System) from PCIT
- Allows for observation of the child across several conditions
- Introduces a novel person
- Gives benchmark for where treatment will begin

SMBOT

- PHASE 1
  - Child and parent alone
  - “Follow your child’s lead in the play”
- PHASE 2
  - Child and parent alone
  - Parents ask questions
- PHASE 3
  - Child and parent alone
  - Stranger comes and sits on periphery
- PHASE 4
  - Stranger joins in play
  - One question to child

TALKING MAP

	Home	School					Grandma's House	Gymnastics	Soccer	Store
		Main Classroom	Gym	Art	Music	Science				
Mom										
Dad										
Aunt Susie										
Grandma										
Siblings										
Teachers										
Peers										
Store Clerks										
Strangers										

Our goal is to fill this Talking Map with as many X's as possible. An X represents the child's ability to verbalize to this person, in this setting and/or activity.

brave buddies
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TREATMENT

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Goals of Treatment

- **Increase** number of people, places and activities in which the child is talking responsively and spontaneously (Build Brave Muscles)
- **Develop** distress tolerance (Child, Parents, Teachers)
- ~~Decrease anxiety~~
- **Generalize** gains made to real world settings

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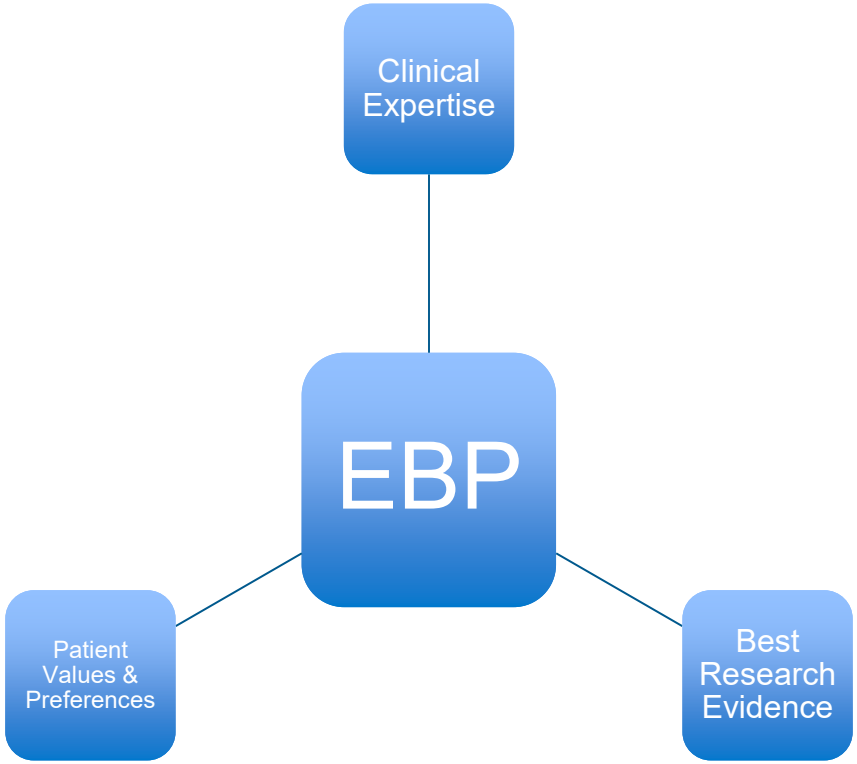
Evidence-Based Practice

- Evidence-Based Practice (EBP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences.
- Evidence Based Treatment (EBT): Treatment backed by scientific evidence
  - Proven to be safe and effective



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What is Evidence-Based Treatment?

- **Well Established Treatments**: Very strong research support, at least 2 Randomized Controlled Trials (RCTs) conducted by independent investigatory teams working in different settings and not affiliated with the treatment developers
- **Probably Efficacious Treatment**s: supported by research but lacking independent research support
- **Promising Treatment**: possibly efficacious with minimal research support
- **Experimental**: Being used but not tested properly
- **Potentially Harmful**: does not work, tested and no positive findings

Effective Treatments for Anxiety

- Cognitive Behavioral Treatment
  - *8 years and above (requires meta-cognition and well-developed verbal skills)
- Behavioral Treatment
  - *2 to 7 years
- Psychopharmacology

Ineffective Interventions

- Forcing, coaxing or demanding that a child speak
- Embarrassing the child for not speaking
- Punishment for not speaking
- Demanding verbal manners such as; “thank you,” “please,” “hello,” and “good-bye”

a treatment approach that does not **generalize

Generalization Of Gains To Real World Settings

Treatment sessions move systematically from the therapist's office, to school, and the child's real world settings

When is Combined Treatment Clinically Warranted?

Less severe impairment	**More severe impairment**
No BT trial in past	**Poor prior BT response**
Low comorbidities	**High comorbidities**
Family history not strong	**Strong family history**
Meeting BT benchmarks	**Not meeting BT benchmarks**

What Does Treatment Look Like

- After evaluation and feedback
- ALL TREATMENT STARTS WITH PSYCHOEDUCATION
- Treatment as usual (e.g. weekly)
- Intensive treatment
- Groups/Brave Buddies

Why Even Consider Intensive Treatments?

- Every day of impairment
  - Is ***not*** neutral
  - Strengthens their habit of avoidance
  - Strengthens others perceptions that they are the child who doesn't talk
  - Decreases ***self-efficacy***
  - May be demoralizing
  - Increases risk of longer term sequelae
- Standard treatment can take too long
- Even worse for non-responders

Limitations of Regular Dosing of Treatment

- Takes a long time at best
- Only treat one child at a time
- Many families (*most)* are without local resources
- Scheduling is not matched to school year well
- Warm-up time eats up huge % of session time

Indications for Intensive Treatment

- Families without local resources
- High severity
- High comorbidity
- Time sensitive school changes
- Legitimate option now for all from the start to reduce illness duration
- Desire to “kick start treatment” and gain momentum
- Finances

Brave Buddies℠

- Intensive delivery of intervention→ 5 hours a day, 5 days
- Analog classroom
- Involves overlearning and repetition
- 1:1 ratio with plan to change counselors as needed and decrease # as days progress
- Increasing challenges across days (field trips, visitors, peer to peer)
- Parent training/support
- High degree of reinforcement
- Addresses comorbidity (separation, social anxiety)
- GENERALIZATION

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Familiar with PCIT or TCIT?

- Parent-Child Interaction Therapy

Or

- Teacher-Child Interaction Therapy

Adaptation of PCIT

- Places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns
- PCIT is well supported and adaptations are supported, as well (Carpenter, Puliafico, et al., 2014)
- Teaches skills, models and coaches

Based on (Social) Learning Theory

- PCIT-SM reverses the cycle of
  -Avoidant child behavior
  -developed through
  negative reinforcement

Adapted from Eyberg, 2010*

- PCIT-SM creates an upward positive spiral of
  -differentially approving and consistent parenting behaviors
  -developed through
  reciprocal positive reinforcement

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Gradually and Systematically

- Sensitize a child to our presence and to verbalize in our presence through skills
- Mindfulness to changing variables
- Teach parents skills to help them be interventionists

Targeted Practice

- **Exposure**
  - **An Approach Task** that helps the child successfully encounter or experience the very thing that they have been avoiding
- **Success- oriented**
- **Repetition-Consistency-Momentum**
- **Paired with Reinforcement & Distress Tolerance**

Lindsay's Brave Talking Sheet

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School Consultation

- Essential part of treatment
- Begins with gathering information
- Education
- Training
- Consultation
- Intervention
- 504/IEP

Any questions?

Thank you for joining us!

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Helpful Resources

- **Selective Mutism Association** [Formerly known as the Selective Mutism Group (SMG)]
- **Child Mind Institute (CMI)**
- **American Academy of Child and Adolescent Psychiatry (AACAP)**

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