



Selective Mutism 101
Parent & Educator Workshop
Rachel Busman, PsyD
Clinical Psychologist
Director, SM Service

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/
workshop-series](http://childmind.org/workshop-series)



Medication: Its Role in Treatment and School

Presented by Ron Steingard, MD, Associate Medical Director;
Senior Pediatric Psychopharmacologist
Tuesday, October 20, 2015
8:30 AM – 10:00 AM



Classroom Management Techniques

Presented by David Anderson, PhD, Senior Director, ADHD and
Disruptive Behavior Disorders Center
Tuesday, October 27, 2015
4:00 PM – 5:30 PM



Building Brave Muscles: Behavioral Treatment for Selective Mutism

Presented by Laura Kirmayer, PhD, MSW, Director of Brave Buddies;
Associate Psychologist, Anxiety and Mood Disorders Center
Wednesday, November 18, 2015
6:15PM – 7:30PM

WELCOME!

- SM workshop series
- On site and live streamed
- Archived
- View in order
- Share with others

Outline of Our Time Together

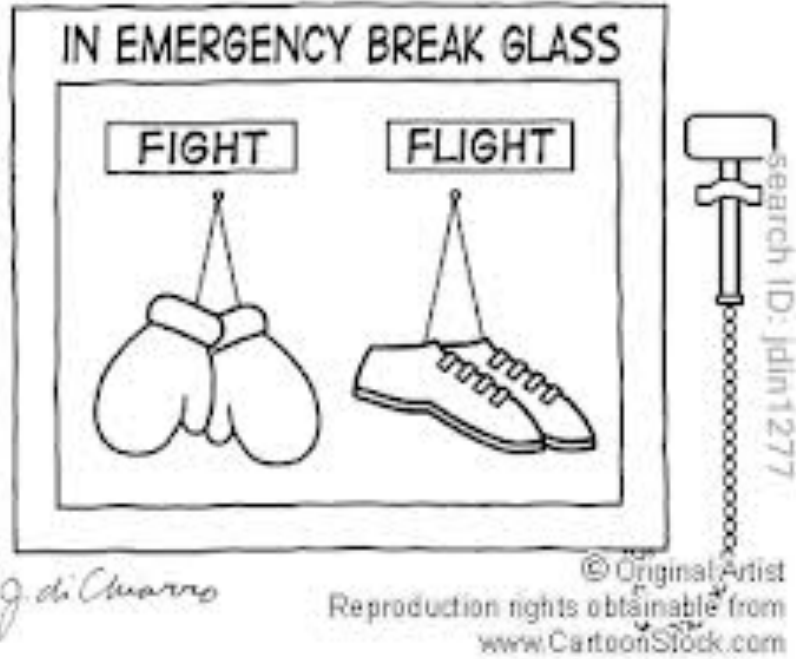
- Anxiety Overview
- What is Selective Mutism?
- Prevalence
- Debunk the Myths
- Nature- Nurture
- Assessment
- Treatment

ANXIETY OVERVIEW

Anxiety: Typical or Atypical?

- Anxiety is a normal and adaptive system in the body that tells us when we are in danger
- This system goes through various stages of development
- Anxiety becomes a problem when the body tells us there is danger when there is no real danger.

Fight or Flight



engage

Fight

Face

repel

attract

Flight

Freeze

dis-engage

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'

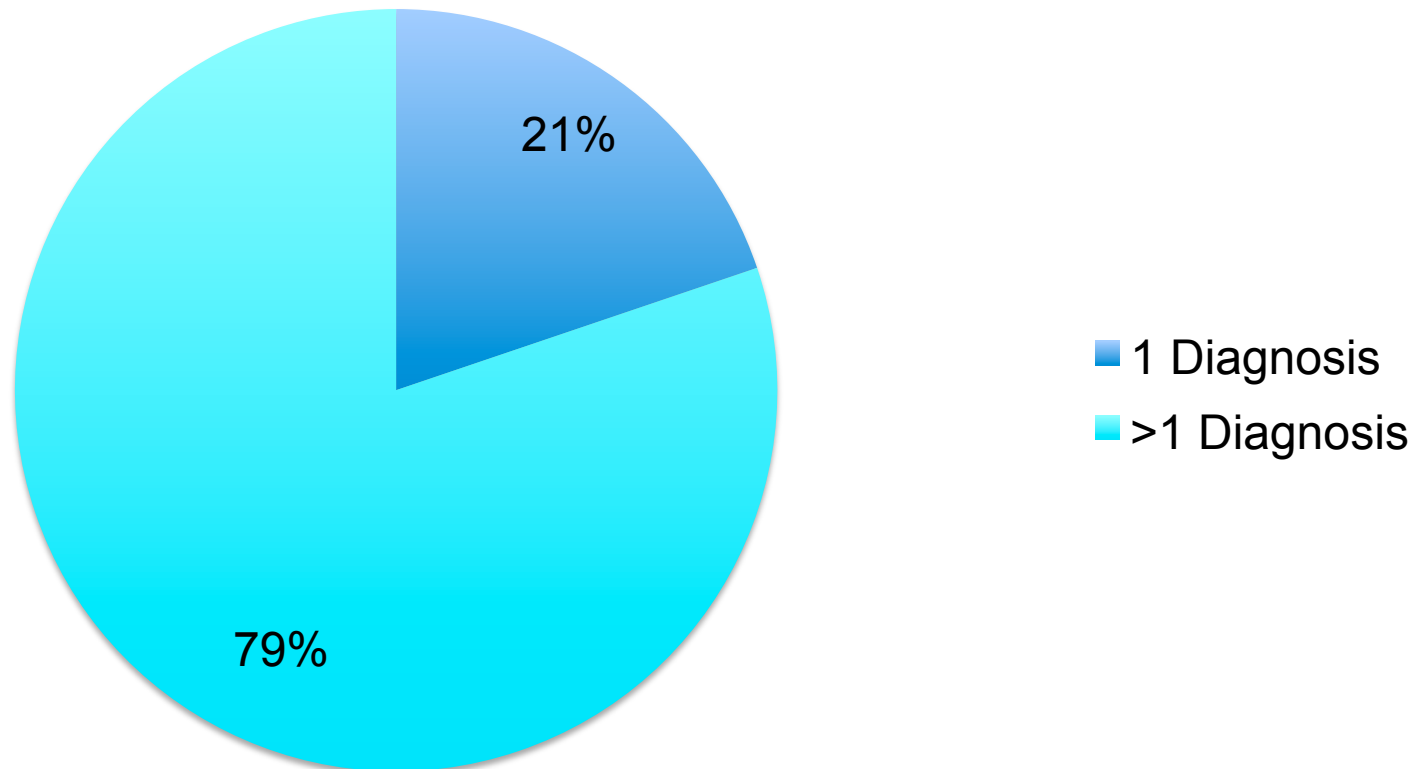
Frequent False Alarms
and
Difficulty Resetting



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
- It is estimated that less than one third of youth with anxiety disorders seek treatment and even fewer receive evidence-based treatment

Comorbidities Among Child Anxiety Disorders



Kendall, Brady, & Verduin (JAACAP; 2001)

Untreated Anxiety

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

The Good News

While anxiety disorders are the most diagnosed, they are also **highly treatable**, especially when caught early

WHAT IS SELECTIVE MUTISM?

What is Selective Mutism?

- 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

Why Do We Care About Selective Mutism (SM)?

- Because children with SM clam up in public but typically talk like fabulous little chatterboxes at home
- Because children with SM suffer in silence
- Because SM is relentless if you have it
- *Just try not talking for a day*
- *Count how many people you talked to today.*

You Are Impaired When...

- You get on 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 pass
- You are sick and don't tell your teacher you need to go to the nurse
- You know the answer and don't raise your hand
- Can't tell your friend "I have that toy, too"

Some Facts About Anxiety In General

- About 8% of all youth have an anxiety disorder
- About 9% of all preschoolers impacted by anxiety
- Delay to seek treatment more norm than exception (can be months or years)
- Untreated anxiety disorders → host of negative outcomes

nami.org; ADAA.org; NIMH.org

PREVALENCE

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)

DEBUNK THE MYTHS

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 language related difficulties appear to be a significant risk factor for the development of SM

What Is The Role Of The SLP?

- Speech and language evaluation
 - ✓ Rule Out
 - ✓ Describe associated difficulties
- Coordinate intervention
- Consistent response among all adults

NATURE VS. NURTURE

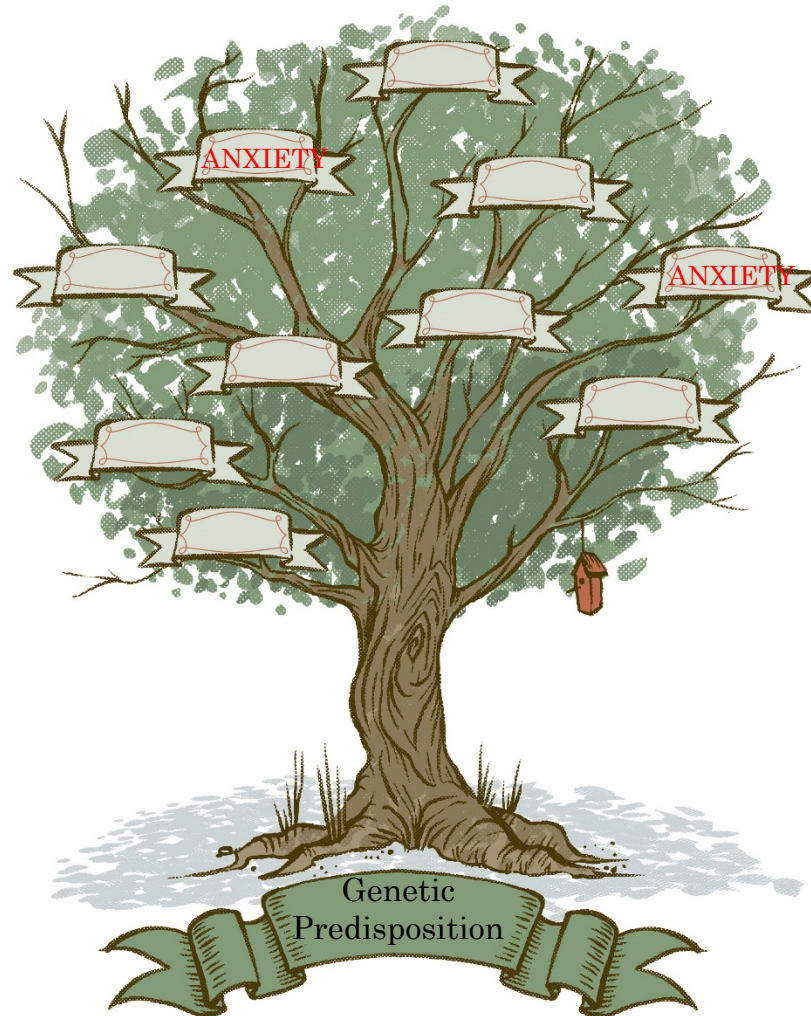


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Current Conceptualization of Selective Mutism

Nature and Nurture

Nature



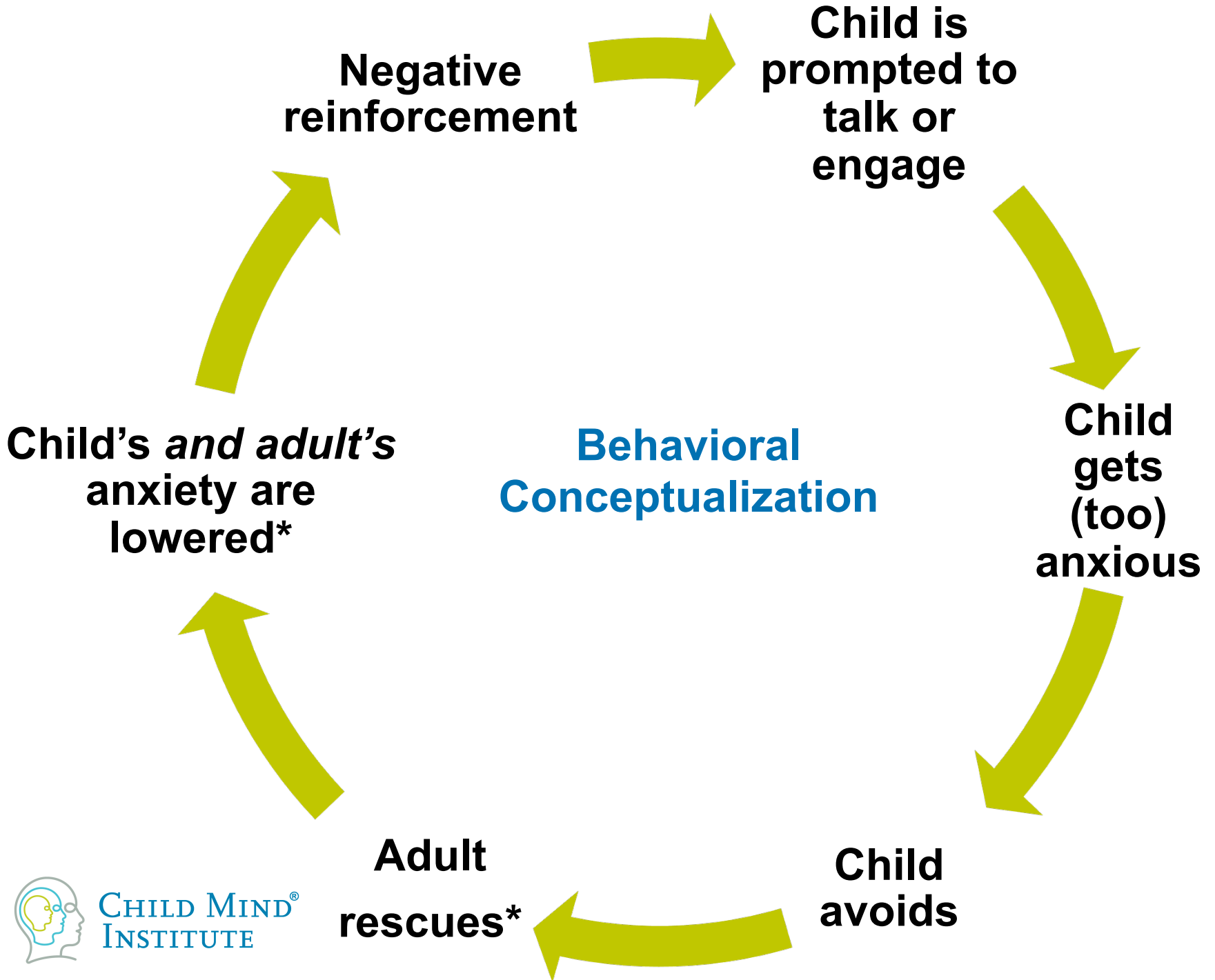
Nurture



The Environment's
Role in Shaping the Inhibited Stance



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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 with SM divide the world into those they talk with and those they don't
- Boundaries are not fluid
- Multiple variables influence these boundaries



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



A Diagnostic Evaluation and Talking Map Are the Starting Places



ASSESSMENT

Evaluation

- Clinical Interview(s): KSADS or ADIS
- Rating Scales: normed and objective
- SMBOT: observation of dyad
- Communication with School
- 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

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.



TREATMENT

Goals of Treatment:

- To have the child verbalize to more people, across settings and activities
- &
- Develop Distress Tolerance

Effective Treatment

- 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

- Obviously before we start treatment we fully evaluate the child
- How are SM evaluations different from more traditional evaluations?
- What's TAU at CMI?
- Why intensive treatment?

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
 - Increase 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 – only ~60 TPs in SMG 😞
 - **Most children with an anx d/o have >1**
- Scheduling of TAU not matched to school year well
- Warm-up eats up huge % of session time

Indications for Intensive Treatment

- Non-responders
- Families without local resources
- High severity
- High comorbidity
- Time sensitive school changes
- Legitimate option now for all from the start to reduce illness duration

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)
- High degree of reinforcement
- Addresses comorbidity (separation, social anxiety)

Adaptation of PCIT

- Places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns
- PCIT as well supported and adaptations supported as well

Familiar with PCIT or TCIT?

- Parent-Child Interaction Therapy
- Or
- Teacher-Child Interaction Therapy

Based on (Social) Learning Theory



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

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

Adapted from Eyberg, 2010*

Gradually and Systematically

- *Sensitize child to our presence and to verbalize in our presence through skills
- *mindfulness to changing variables

Targeted Practice

- **The Special Sauce**
 - Exposure: An exposure is 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**

Helpful Resources

- **Selective Mutism Group (SMG)**
- **Child Mind Institute (CMI)**
- **American Academy of Child and Adolescent Psychiatry (AACAP)**



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