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Selective Mutism: What it is and Approaches to Intervention

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Abstract

Selective Mutism (SM) is a frequently unheard of and misunderstood mental disorder. While it is defined in the DSM-5, its misconceptions are still very high. This thesis will provide a historical and current literature review of selective mutism research, as well as different treatment approaches in clinical and school environments. The hope is that with a wider understanding of what selective mutism is and is not, treatment for the disorder will begin at a younger age. The goal is for a child's team to be included in the process of treatment, including the mental health provider, parents, caregivers, teacher, and other significant people in the child's life.

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Introduction

Selective mutism (SM) is a less heard about and understood mental disorder that affects many individuals, especially youth. The essential diagnosis feature of selective mutism is the persistent failure to speak in specific social situations (e.g., school, with playmates) where speaking is expected. In order to receive the diagnosis, these symptoms must be present for at least one month, not including the first month of school when children may not be confident to speak up in the classroom yet. Instead of communicating verbally, children with selective mutism often use gestures, nodding, pushing/pulling to communicate (Kryzanski, 2003). One reason this mental disorder may be less discussed and understood is that it is very hard to know the prevalence. Often cases go undiagnosed because of variations in diagnostic criteria, rarity of the condition, or lack of information in general (Busse & Downey, 2011). The etiology of the mental disorder also remains unclear. Most of the scientific findings on SM are based on case reports or very small research populations.

This thesis will go on to explore what selective mutism is, how to better understand it, and make an argument for different approaches that can be used to treat it. It will include chapters on "Conceptions, Research, and Treatment Approaches," "My work with the Child Mind Institute," 'Other Approaches," and "Discussion." The hope is that this thesis will take you through a history of the diagnosis of selective mutism as well as give an in depth explanation of behavioral treatment. It will also include psychoeducation about different treatment approaches and limitations to treatment and how teachers and parents can help children with SM.

Chapter 1: Conceptions, Research and Treatment Approaches

DSM and Diagnostic Criteria

The Selective Mutism Association describes SM as an anxiety disorder where a child or adolescent is unable to speak in one or more settings such as school, public places, with adults, but is able to speak comfortably in other settings, such as at home with the family (SMA, 2018). Selective mutism is in the anxiety disorders section of the DSM-5.

> The diagnostic criteria are, "the child shows consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g. at school despite speaking fully at home with their parents) the disturbance interferes with educational or occupational achievement or with social communication, the duration of the disturbance is at least 1 month (not limited to the first month of school), the failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation, and the disturbance is not better explained by a communication disorder (e.g., child-onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder," (APA, 2013, p. 195).

Selective Mutism criteria have been continuously changing. In 1877, Kussmaul described a disorder he named aphasia voluntaria. This mental disorder described individuals who do not speak in certain situations, even though they are fully able to speak in situations they are comfortable in. The name emphasized a voluntary decision not to speak (Krysanski, 2003). From there on the first DSM-1, which was published in 1952, did not contain selective mutism as a mental disorder. The DSM-2, published in 1968, also did not define selective mutism. While the term elective mutism was coined in 1934 by Moritz Tramer, it was not used in the DSM until 1980. In 1980, the DSM-3 came out and included this version of SM called "elective mutism." The diagnostic criteria of elective mutism was a chronic refusal to speak in most social situations. It also stated that in some children, there was a presence of delays in speech development and articulation disorders (Holka-Pokorska, Piróg-Balcerzak, Jerema, 2008). The term "elective mutism" was significant because it highlighted a *refusal* to speak. It defined this mental disorder as oppositional, stubborn, or defiant behavior (Holka-Pokorska et al., 2008). It

was based on refusal to talk and conscious withdrawal from verbal contact with others (Holka-Pokorska et al., 2008). In the DSM-3-R, which came out in 1987, elective mutism specifically stated that the refusal to speak is not due to symptoms of social phobia (Newman, 2004).

In the DSM-4, the term "elective mutism" was changed to "selective mutism." This name deemphasized this refusal and oppositional aspect of the disorder. Instead, it highlighted that in select environments, the child is *unable* to speak rather than choosing not to (APA, 1994). The selective mutism occurs in some selected environments, but not necessarily all. Compared to the DSM-4, the DSM-5 moved selective mutism from "disorders of childhood and adolescence" to the "anxiety disorder" category in the DSM-5 (Holka-Pokorska et al., 2018). It is also important that the DSM-5 highlights that language deficits are not an essential feature of selective mutism. While occasionally some children with SM may have a coexisting language disorder, the DSM-5 criteria clearly states that the SM diagnosis should not be better accounted for by a communication disorder. The disorder should also not be diagnosed if the child's inability to speak is a result of inefficient knowledge of the language or comfort to speak the language expected. For example, immigrant children who are entering a school system for the first time would not be given this diagnosis (Krysanski, 2003).

Selective Mutism continues to be slightly more common in girls than in boys, but still is a rare disorder found in less than 1% of individuals. Again, the misconceptions and lack of agreement about the selective mutism diagnosis may be contributing to this small percentage of children with the official diagnosis. It is very likely that a higher percentage of children who have selective mutism are missed, undiagnosed, or misdiagnosed. The onset of the disorder occurs most frequently before a child turns five years old, but it is often not discovered until the child goes to school. This is because most children with SM speak at home with their parents

without inhibition, but the inhibition arises in new settings with unfamiliar people (Krysanski, 2003).

More than 90% of children with SM also meet the diagnostic criteria for social anxiety disorder, now termed social phobia (Black et al., 1995). Since many children with SM also are diagnosed with social anxiety, distinguishing between them can be sometimes difficult.

> The DSM-5 defines social anxiety as, "A persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be embarrassing and humiliating. Exposure to the feared situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally pre-disposed to Panic Attack. The person recognizes that this fear is unreasonable or excessive. The feared situations are avoided or else are endured with intense anxiety and distress. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia. The fear, anxiety, or avoidance is persistent, typically 6 or more months. The fear or avoidance is not due to direct physiological effects of a substance (e.g., drugs, medications) or a general medical condition not better accounted for by another mental disorder." (APA, 2013, p.202)

It is important to emphasize that a child with SM does not have to have social anxiety. Some children with SM are able to participate fully non-verbally, such as playing with their peers at recess or participating in dance class. Other children with SM might stand up in front of the class, but just not speak verbally. Some are also "class clowns" in the sense that they may act very silly and disruptive in class, seeking attention from their peers. In these instances, the children with SM does not necessarily have social anxiety although often there is a co-occurrence. The silliness may be caused from anxiety or the child may be comfortable in their environment, so it is important for a clinician to look into the behavior more closely and see what triggers the behavior. If the child just has selective mutism, they often will be playing with other kids on the playground or gesturing when making a choice. Kids with social anxiety will be less likely to run around playing with the other kids or even making choices by gesturing. The age of

onset is also very different for selective mutism as opposed to social anxiety (Cumba, 2014).

While some kids' SM may cause them to have stiff body language, a blank facial expression, or

to withdraw into a corner during recess to play alone, the driving force of this is to avoid other's

forced attempts at getting the child to speak. SM occurs between the ages of three and six but

social anxiety typically manifests between ages eleven and thirteen (Wong, 2010). Social anxiety

requires a certain degree of cognitive development which is not necessarily the case for SM.

Theories of the origin of SM

Holka-Pokorska, Piróg-Balcerzek, & Jerema (2018) discussed the different theories

surrounding selective mutism, including behavioral, psychodynamic and systemic theories.

Behavioral theorists believe that in new social situations the sympathetic nervous system takes

inhibiting control of the ability to speak. Therefore, children in "threatening" situations, such as

new social situations, behave as if they are "frozen," (Holka-Pokorska et al., 2018). This is called

a behavioral theory because the mutism occurs from a long period of negatively reinforced

learning patterns (Leonard & Topol, 1993). The mutism is a child's adaptive response to the

environment rather than a pathological one. The failure to speak is a learned strategy for

manipulating the environment in response to a variety of social triggers (Wong, 2010). In other

words, silence is a learned coping mechanism for anxiety. Often at a young age, adults may

overcompensate for their child's "shyness" trying to protect them from the outside world. For

example, at family outings a young child may hide behind his or her mother's legs when a

stranger comes up and asks the child their name. The adult, being in a protective role, answers

for the child instead of having the child answer themselves. This cycle is negatively reinforced

over time and the child learns that being silent lets them escape from the anxiety over

expectation to speak. The environment plays a huge role in shaping the child's inhibition. The

Child Mind Institute, a center that focuses on behavioral therapy for children's mental disorders, describes the cycle of negative reinforcement for SM which can be seen below.

The cycle of negative reinforcement
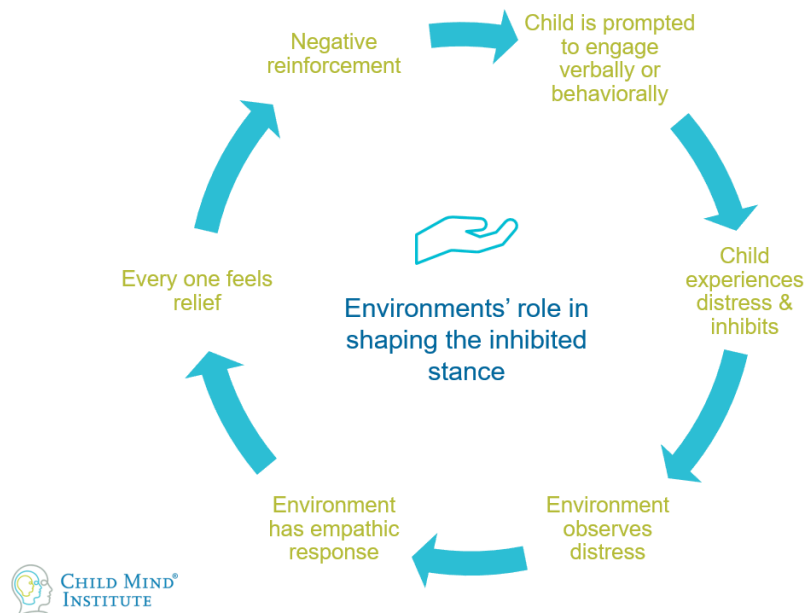
This cycle leads to a "contamination effect." The contamination effect prevents children with selective mutism from speaking to those they have a history of not speaking to. It is a learned history (Child Mind Institute, 2018). From this behavioral theory, the behavioral approach to treatment is focused on using different techniques to decrease anxiety and promote speaking. It is a goal-oriented therapy that uses behavioral modification such as shaping, stimulus-fading, self-modeling, contingency management, and positive reinforcement, (Fernandez and Sugay, 2016).

Psychodynamic theories about selective mutism are based on the concept that there is an intrapsychic conflict. The mental disorder comes from a child's reaction to an unresolved oedipal conflict at the oral or anal stage of development, as described by Freud. The anger towards a same-sex parent is a defense mechanism and is displayed as silence from the child (Dow et al., 1995, Giddan & Milling, 1999). Yanof (1996) argues that, "Mutism is a symptom, not a syndrome. It is a compromise formation that occurs when the very act of speaking becomes

engaged in conflict. The child attaches unconscious meaning to the act of speaking. Frequently, speaking becomes "dangerous" because the child equates it to an act of aggression. Not speaking then becomes the child's way of defending against this forbidden impulse as well as partially expressing it, because silence can also be hostile." Based on this theory, the psychodynamic perspective believes play therapy can help resolve these types of conflicts which should ultimately help alleviate selective mutism symptoms. The safe environment that play therapy creates allows the child to communicate in whichever they want, without putting any pressure to speak (Hultquist, 1995). In this therapy, the child "takes control" over his or her play in order to come to terms with their real self. It enables the child to solve their own problems with their own timing.

There has also been a systemic theory approach to selective mutism which emphasizes that heavy parental control over children may lead to over dependence. Systemic theorists believe this parental control causes children to be too attached to their parents and fear strangers, causing a lack of verbalizations (Holka-Pokorska, Piróg-Balcerzek, & Jerema (2008). This theory emphasizes that the mental disorder stems from conflicting family relationships. The families of these children have characteristics of, "intense attachments and interdependency, fear and distrust of the outside world, fear and distrust of strangers, language and cultural assimilation difficulties, marital disharmony, or withholding of speech practiced by one or more of the parents in the home," (Meyers, 1984). Family systems therapy emphasizes an intervention that treats the family dysfunction rather than the child's specific symptomology. Kristensen (2000) found that in a group of children with selective mutism there were higher instances of movement of schools at a young age or divorce/changes in family life. This study concluded that changes in family or school environments early on in a child's life may be a risk factor. Family systems therapy is a less used approach to selective mutism compared to behavioral therapy.

Misconceptions

The misconceptions about selective mutism come from different sources. Some of the confusion between definitions in past years, which was described in the literature review, is part of the problem. Still today, many people do not agree on what selective mutism really is or is not. Another reason there may be misconceptions about the disorder is that it may either go unnoticed or teachers may not act upon it. This may be because the presentation may be a child just being "shy," especially at a young age. Kids with SM are often just on the sidelines in school and complete all the tasks that are asked of them just nonverbally. For these reasons, teachers may not act upon or fully realize that the child needs help. For example, these children often listen to directions and finish their writings tasks. These children are often well behaved in the classroom. Therefore, the child may not show noncompliance in school except for reading out loud in reading group or standing out to share the schedule during morning meetings. The need for verbalizations becomes a larger problem as the children get older.

There are many myths that have contributed to a misunderstanding and confused perception of selective mutism around the world. These myths include that, "selectively mute children have been traumatized or abused, selective mutism is just shyness and the kids will grow out of it, kids with selective mutism have speech problems, children with selective mutism are oppositional or manipulative, children with selective mutism can speak if adults make clearer demands, and selective mutism is a form of autism," (Child Mind Institute, 2018).This is a clear summary of the different myths that affect children with the mental disorder and create a roadblock for the possibility of therapy. These myths also affect the way adults understand the disorder. In order for these myths to be debunked, it is important to educate mental health providers and teachers about what selective mutism really is and why these myths don't hold up.

It is also critical for the child's "team" to understand what SM is. The child's team includes the

child, the child's family, relatives, teachers, peers, and other significant people in their life.

The first myth in this list is "selectively mute children have been traumatized or abused"

(Child Mind Institute, 2018). This assumption was made in older case studies of SM, but there

was no clear evidence offered. There is an important distinction to be made here. Children who

have been traumatized may become mute, but it is important to understand that selective mutism

does not typically start from a traumatic experience. Moreover, when children endure trauma and

become mute, they are often mute in *all* situations whereas children with selective mutism are

mute in specific social environments (Child Mind Institute, 2018). Children with SM typically

speak in at least one setting and are rarely mute in all settings. Their mutism is specific to anxiety

around speaking expectations and social encounters (SMA,2018). Children with traumatic

mutism usually develop the mutism very suddenly and in all situations. They are unable to

process the traumatic event and therefore the mutism arises. An important note here too is that

some children with SM may start out being mute in just some situations, such as in school.

However, as the negative reinforcement cycle continues, the child may become mute in more

or/and all situations (SMA,2018). Also, post traumatic stress disorder has many different

symptoms differentiating itself from SM, such as trouble sleeping, nightmares, and the recreation

of the traumatic experience in the child's mind. Black and Uhde (1996) also argued that, "while

there may be a legitimate concern that selectively mute children would be unable

to speak out if they were victims of abuse, there is no reason to assume that such abuse is any

more likely to be occurring with these children than with the average child," (Stanley, 2018, p.2).

Again, children who are traumatized may have selective mutism, but it is not a direct correlation

and typically the symptomology differs

The first myth is that, "selective mutism is just shyness and the kids will grow out of it"

(Child Mind Institute, 2018). Shyness and other anxiety responses can be totally typical for many children. However, there are three ways to know when anxiety becomes a disorder. The first is the frequency, which is that the child experiences anxiety serval times over a span of time. The second is the duration, which is that the anxiety interferes for an extended period of time. The third is the impairment. This is when the anxiety interferes with the child's development and the child cannot go about his or her daily life and activities (Child Mind Institute, 2018). It is important to understand that selective mutism is an anxiety disorder and that children who are selectively mute are very anxious. They freeze from their anxiety which causes them to be nonverbal. The level of impairment for children with SM is much more than shyness. They are often unable to raise their hand in class, ask to go to the bathroom, or ask for help when they are hurt (Cumba, 2014). They will often wait until the end of the day to verbalize their problems with their parents when they are picked up. They often also have trouble asking for help with their classwork and therefore, may fall behind in the lesson.

The next myth is, "kids with selective mutism have speech problems" (Child Mind Institute, 2018). It is important to understand that while some children with SM may have a speech delay, the conditions are not directly related (Child Mind Institute, 2018). Many kids with SM do not have any speech problems and can fully verbalize in their homes. Since they are not speaking to unfamiliar adults, they may not be able to complete assessments at schools which ultimately determines their speech problems (even if they are not a factor at all). Many children with SM are placed into language and speech therapy because of their non-verbalization, rather than getting the correct therapy for the actual SM. Black and Uhde's (1995) research showed no developmental delays in children with SM. While some children may have some language delays, it is not a necessity in the DSM-5 nor a "norm." A communication disorder will be

apparent in all situations while SM is only noticeable in specific social situations (Child Mind Institute, 2018).

An interesting point to bring up is that selective mutism is more common among children who speak a second language (Child Mind Institute, 2018). It is critical to understand that being bilingual does not cause SM, as specifically explained in the DSM. However, SM is an anxiety disorder and when bilingual children are expected to use a language that they are not comfortable speaking in, they can be at a higher risk of developing SM. There is a difference of how SM symptoms in bilingual kids may appear. Some kids will only be non-verbal in their second language, while others may stop speaking in both their native and second language. When conducting an assessment, the clinicians must be very careful to ensure their SM diagnosis is not due to a child being *unable* to understand or use a second language. Also, in the beginning of a bilingual child learning a new language, they often go through a period where they do not speak and this is also not the correct time for diagnosing (Child Mind Institute, 2018). Therefore, bilingual children still develop SM and actually at a higher rate than non-bilingual children, but this is not the cause of the SM.

The fourth myth is, "children with SM are oppositional or manipulative" (Child Mind Institute, 2018). There has been past research that has added to this myth in the SM literature. In an early research study that looked at 20 children who were diagnosed with SM from the DSM-III, Krohn, Weckstein, and Wright (1992) found that 90% of the children were "controlling, negative, or oppositional in both verbal and nonverbal situations." The idea of children with SM being oppositional is contingent with the previous definitions of SM that describe it as a child's *refusal* or *choice* to not speak. The term "elective mutism" actually emphasized this refusal. There was also a factor of "bad parenting" that went with the term elective mutism. As this thesis has gone on to argue, this is not the case. These children have been negatively reinforced in their

cycle of anxiety. While some parent and teacher reports describe children as oppositional, there is a hypothesis that some adults interpret these avoidance behaviors as controlling while they are actually extreme anxiety (Kristensen, 2000; Yeganeh et al., 2003). Research by Cunningham et al., (2006) suggests that these parent reports of SM children demonstrating oppositional behaviors may be solely in speech-related situations. Children with SM are often misdiagnosed as having oppositional defiant disorder, due to their inability to meet speaking expectations in school and other activities. This myth may create even more of a negative cycle for the child, as they are often scolded or told to "listen!" which may heavily spike their anxiety even more.

The next myth is, "children with SM can speak if adults make clearer demands" (Child Mind Institute). Selective mutism actually is a strong anxiety about pressure and expectation to speak. Therefore, demands are actually causing the child with SM to freeze up. The selective mutism association argues that, "The expectation of speech is a trigger of severe, paralyzing anxiety for selectively mute children. Instead of the embracing the simplistic notion that mutism will stop when reinforcers are removed, teachers, parents and therapists must understand that these children need interventions to reduce anxiety, as well as instruction on recognizing and coping with their anxious feelings before any speaking goals are placed on them," (Stanley, 2019). Children with SM need to feel comfortable and supported while trying to work through their anxiety. There shouldn't be a quick expectation to speak but rather a slow plan to work through increasingly difficult situations with a lot of positive reinforcement and support.

The last myth is, "SM is a form of autism." Children with autism will have consistent problems interacting socially and in all different environments while kids with SM will just be nonverbal in certain settings. Children with solely SM do not lack social and communications skills but rather are frozen from anxiety. However, often these two disorders may look alike in that when children with SM are anxious, they may avoid eye contact or have a blank expression

on their face (Child Mind Institute, 2018). Kids with autism do not have the "selectivity" piece of their diagnosis. They are not specifically anxious in certain settings, environments, or with certain audiences. The selective mutism association argues that one of the best ways for clinicians to rule out autism is to observe videotapes of the child in his or her most comfortable environment, which is typically the home (Stanley, 2019). Children on the autistic spectrum will display symptoms that are more uniform whether it is in a setting they are comfortable in or a setting that is new to them. They will have a consistent difficulty keeping eye contact or speaking to others, whether it is their family or strangers. Children with SM will not display symptoms consistent with their SM at home. With their family or other people they are comfortable with, children with SM will be spontaneous in conversation, speaking in a full volume, and keeping eye contact.

In a Child Mind Institute parent training slideshow for selective mutism, it is clearly explained that SM is *not* elective mutism, social phobia, trauma related, outgrown, shyness, autism, cognitive deficits, or language disorders (Child Mind Institute, 2018). Instead, selective mutism is a product of nature and nurture. On the nature side, it is our biological predisposition or genetic make-up. This is something therapy cannot change. However, on the nurture side, the child has a reinforced inhibition with their environment. Therapy can help the child to engage verbally or behaviorally.

Social anxiety (SA) versus selective mutism

Social anxiety and selective mutism often have similar presentations but it is important to understand the critical differences when thinking about intervention. As discussed in the DSM criteria section, many children with selective mutism also have social anxiety. It is important to understand that while children with selective mutism have anxiety, it is not necessarily that they are socially anxious but rather that there is anxiety and rigidity over the need to speak in

expected situations. The relationship between social anxiety and selective mutism has changed and been questioned throughout the years.

The Bergman et al., (2013) study emphasized an important difference between selective mutism and social anxiety. Selective mutism and social anxiety co-occur at very high rates (Bergman et al., 2008; Black & Uhde, 1995; Dummit et al., 1997) and with a baseline co-occurrence of 85.7% in an integrated behavior therapy randomized controlled study (Bergman et al., 2013). In this study, Bergman et al., (2013) sought out to research how well behavioral intervention (Integrated Behavior Therapy for Selective Mutism) may treat children with selective mutism. However, although they were not implicitly seeking it out, they also found some results regarding the discrepancy between social anxiety and selective mutism. Social phobia was assessed as a secondary outcome measure. SM appears to be a strong indicator of future social anxiety disorders (Steinhausen, Wachter, Laimbock, & Metzke, 2006). Bergman et al. (2013) believed that this showed the relationship between SM and SA to be complicated. The results of the study first found that social phobia symptomology decreased following behavioral intervention based on parent reports. However, teachers reported that after behavioral intervention, children with SM were speaking at school but their social anxiety did not decrease. This is an interesting question regarding social anxiety and selective mutism. The disorders do have a high co-occurrence rate, and the patients in this study also demonstrated this co-occurrence in disorders. However, they also found that a reduction in social anxiety was not evident in every individual in the study, though their speech improved. They compared their finding to those of previous investigators that, "the failure to speak in certain situations may be a form of behavioral avoidance that successfully serves to decrease social anxiety (Bogels et al., 2010; Yeganeh et al., 2006). Thus, it is plausible that if speech avoidance is reduced from integrated behavior therapy for selective mutism, the child's experience of social anxiety could

remain unchanged or even increase in some settings as a result of more frequent exposure to and engagement in the feared situation, despite improvement in functional impairment (Bergman et al., 2013). Therefore, if social anxiety and selective mutism are co-occurring, it is critical for there to be different treatments plans for both. While a child's speaking may be improving, there needs to be certain exposures also dedicated to the social anxiety.

Behavioral Therapy

Currently, the leading evidence-based treatment for selective mutism is behavioral. This type of therapy focuses on modeling and prompting speech, followed by positive reinforcement techniques. It is goal-oriented and often includes exposures to anxiety provoking stimuli. The research by Bergman et al., (2013) included a total of 21 children ages 4 to 8 with a primary diagnosis of selective mutism. These children were randomized and assigned to 24 weeks of integrated behavior therapy for SM. This behavior intervention included using a feelings thermometer, creating a hierarchy of speaking goals with the children, and reinforcement and praise. Behavioral exposures in the children's school settings were also an important part of this therapy. At the end of the study, results were assessed using blind independent evaluators, parent and teacher reports, a behavioral measure, and a three-week follow-up (Bergman, Gonzelez, Piacentini, Keller, 2013). The results of this study demonstrated a positive effect of selective mutism behavior therapy (Bergman et al., 2013). Specifically, the data showed an increased functional speaking behavior after treatment by parents and teachers. This study was one of the first randomized trials to look at selective mutism behavioral therapy and while it shows a positive outcome, there needs to be more research done on the topic.

Kurtz (2016) explained that selective mutism is maintained by negatively reinforced interactions. Therefore, both the child and the parent learns to avoid certain situations. It is key to remember that both the child and parent become part of this cycle, as well as other figures in the

child's life. Therefore, when looking at behavioral intervention it is critical to involve the "child's team." The child's team varies based on the child but definitely must include the clinician, parents and teachers. Kurtz (2016) also pointed out that one cannot be non-responsive by oneself. The non-responsiveness only happens in a relationship with another person.

This type of behavioral therapy that was just briefly discussed is the practice at the Child Mind Institute where I have been working as a volunteer for the past two years. I will be discussing my experience at the Child Mind Institute in chapter 2, as well as discussing other approaches to treatment in chapter 3.

Chapter 2: My Work with The Child Mind Institute

Child Mind Institute (CMI)

I have worked as a Program Assistant at the Child Mind Institute for 2 years. This is a volunteer position that has enabled me to learn behavioral skills for working with children with SM. I was trained in SM skills, including child directed and voice direction interaction skills to increase verbalizations which will be discussed further in this section. As a program assistant, I have prepared therapy rooms, organized session materials, participated in clinical sessions with children and families, and made brave talking sheets and scavenger hunts for children with SM. The following are my observations from past work as a program assistant for selective mutism and as a one-to-one counselor during Child Mind Institute's Brave Buddies, a group treatment program for children with SM.

Process of Diagnosis

The Child Mind Institute follows an evidence-based behavioral framework for treating children with selective mutism. The goals of treatment are to increase the number of people that the child is verbal with, increase the number of places and activities that the child is verbal in, increase when the child speaks responsively and spontaneously, and to build distress tolerance (for both the child and the parent). When the child works on speaking to new people and in different settings, the Child Mind Institute calls this building "brave muscles" and they also have a program called "Brave Buddies" which will be discussed further on (Child Mind Institute, 2018).

When parents first bring their child who is demonstrating signs of selective mutism to CMI, the first process is a diagnostic evaluation. The clinician learns about the child's history, development, and symptoms. They also collect written evaluations from the parents, teachers, caregivers, pediatricians, therapists, and other important members of the child's life. When the

child is actually brought in for the evaluation, the clinician conducts a live observation. Through an observation room, the clinician watches how the child interacts with just the parent in this new environment versus the child with a new stranger. They pull in other clinicians or interns to be a "confederate" and these strangers go into the room in order to access how the child interacts (or does not interact) with them.

The initial selective mutism coding that takes place during the diagnostic evaluation is called the Selective Mutism Baseline Observation Task (SMBOT) (Kurtz, 2008). It is a behavioral observation system that was adapted from the Dyadic Parent-Child Interaction Coding System (Eyberg, Nelson, Ginn, Bhuiyan, Boggs, 2013). In this observation, there are four standard situations the child is put through.

The first situation is a "Warm-Up." In this situation, the parent is told to follow their child's lead in play and the child can play with whatever toy he or she wants. The second scenario is the "Responsive Speech" situation. In this situation, the parent is told to start asking the child questions. The question format the parents are told to follow are "yes/no questions, forced choice questions, and open ended questions." An example of a yes/no question is, "Do you want to play with these?" An example of a forced choice question is, "Do you want the red block or the blue block?" An example of an open-ended question is, "What should we play next?" The reason for these different questions is that there are varying empirical studies that hypothesize the child to have a significant varying response rate depending on how the question is asked (Kurtz, 2013). Children are more likely to respond to direct parental prompt than neutral talk (Kurtz, 2013). Masty et al. (2009) also had found that anxious children were more likely to respond to open-ended or forced-choice questions compared to other prompts/ neutral talk.

The next situation is called "Confederate." This is the situation where the parent is instructed to keep following the child's lead in play while a stranger enters the room. The

stranger just comes into the room and sits on the side without saying anything. The stranger is instructed to introduce themselves and say that they will just be doing some of their wok in the corner, so they do not actually interact with the child. The last situation is called, "CDI & VDI Trial." The parent is told to continue following the child's lead in play as the stranger actually joins them. The confederate first uses CDI (child-directed interaction) skills, which is a mix of describing what the child is doing, reflecting anything they say, and praising when they verbalize anything. CDI skills do not include any questions or commands. Then, the confederate uses one VDI (verbal direction interaction) sequence towards the end of the interaction, which is a forced-choice question and a follow-up praise if the child responses. These skills will be discussed with parents in depth in the behavioral treatment part following this baseline, when the child actually begins therapy.

Behavioral Treatment Plans

After this evaluation, the therapist sets up a plan for the child to start weekly therapy at the Child Mind Institute. Depending on how the child did in the evaluation and their age, the treatment plan will be tailored specifically to what the child needs. However, there are certain important aspects for most selective mutism behavioral work. For young children, roughly ages 3-8, there is more work done with parent-child relations. The treatment approach is based off of parent child interaction therapy and parents are highly involved in treatment (Child Mind Institute, 2018). It also includes everyone else on the "child's team," such as the child, parents, teachers, and even friends and friends' parents. The treatment is transparent to the child and collaborative. It also focuses highly on debunking myths that are problematic with how the child's team is approaching the child and their anxiety (Child Mind Institute, 2018).

The therapy that is used at the Child Mind Institute follows "PCIT-SM" protocol, which was developed by Dr. Steven Kurtz (Carpenter et al,, 2014). PCIT is parent-child interaction

therapy and PCIT-SM is a similar therapy that also includes SM specific practice. While PCIT focuses on decreasing negative behavior, PCIT-SM focuses on increasing verbalizations. However, both include increasing pro-social behaviors, self-esteem, and parent/child relationships. The big similarities between PCIT and PCIT-SM are that, "the parents are empowered to be agents of change, the parents are taught to increase their distress tolerance, there is psychoeducation about how to set up a child for success and the power of overlearning, and that learning/behavioral theory is driving the assessment and treatment," (Kurtz, 2016). There are different phases in this SM behavioral therapy. The therapy starts out where the child is most comfortable speaking, which is usually with one of the parents and playing a game of their choice. The first phase is child directed interaction (CDI) which has a strong reward/reinforcement component. The parents are taught strong CDI skills which can be remembered with the mnemonic "PRIDE." The "P" stands for labeled praise, the "R" stands for reflection, the "I" stands for imitate, the "D" stands for behavioral description, and the "E" stands for enjoy (Eyberg, 2004). Labeled praise is aimed at telling the child exactly what you like that they are doing. This is important for improving the child's self-esteem and showing them approval (Child Mind Institute, 2018). This type of praise should also be specific to the child's speaking, whenever they do verbalize. For example, "Thank you for telling me that you drew a dog," "Great job telling the class," or "I love that you just told me 'no' in a loud voice." Reflections focus on repeating or paraphrasing what the child says and adults are instructed to do so in a full volume, even if the child whispers. There are many reasons for reflecting, including increasing the rate of verbalization, making the child's verbalizations to others, and showing approval/interest. An example of this is when the child says, "I am drawing a dog," the parent can say, "A dog!" Imitation is when the adult copies what the child is doing with the toys. This shows approval of the play and also follows the child's lead. Description is when the adult says

exactly what the child is doing. For example, a parent says, "You're moving the red block." This decreases the adult "mindreading" what the child is doing and increases the chance for the child to elaborate. Enjoy is the last skill which just means showing enthusiasm when playing the child. This helps the child feel approval and interest in the process. (Kurtz, 2008).

In the CDI component of therapy, adults are asked to avoid questions, commands, and criticism when following the child's lead in play. There is also a huge emphasis to avoid mindreading and accepting non-verbal responses. When an adult accepts a child's nonverbal behavior such as nodding by praising their answer, they are actually telling the child that they don't need to practice brave talking and can get away with the silence. An example of this is when a child shakes their head and the adult says, "You're telling me you don't want to play with this." Instead, parents are instructed to just describe what the child is doing when they use nonverbal gestures. For example, if a child shakes their head no, the parent can say, "I see you shaking your head no." Once they are in the VDI sequence of therapy, they can follow this description with a forced-choice question. If the child continues with the nonverbal gesture, the parent says, "I see you shaking your head. That was a hard one, we'll come back to it later," or something along those lines. This way, the child knows that the nonverbal gesture was not accepted when the question was for a verbal response, but also sees the parent's validation that this will take practice and is challenging for the child. The adult also should not merely guess what the child is thinking. Moreover, questions should not be asked until the next stage. Children with SM need a warm-up period where they can become comfortable in the environment they are in and with no questions/commands.

An important aspect of the therapy is the type of toys used. Toys that should be used for CDI are creative and constructive toys (Child Mind Institute, 2018). Examples of these toys are building blocks, legos, magnetic blocks, Mr. and Mrs. Potato Head, costumes, puppets, cars and

garage, drawing, bubbles, and others. Toys to avoid are ones that directly prompt for verbalizations (Spot it, Bingo, Go fish), toys that have pre-set rules (Candy Land, Monopoly, UNO), or toys that discourage conversation (Video Games, iPad, books) (Kurtz, 2008). The games that prompt verbalizations and have pre-set rules can be put out in the VDI stage of the therapy, which comes next. Another important aspect of the CDI therapy is that parents are encouraged to continue practicing with their child throughout the week when the child is not at Child Mind.

The next stage in therapy is "VDI" which stands for Verbal Directed Interactions. It is important to note that VDI always follows a warm-up with the child, which is solely in CDI. The point of VDI is to give the child opportunities to build their brave muscles (The Child Mind Institute, 2018). The adult is instructed to practice first using forced choice questions and later using open-ended questions. An example of an effective sequence would be asking the child, "Is this block red or blue?" waiting five seconds, and if the child responds and says, "red!" then reflecting this answer loudly and ending with a labeled praise. If the child does not answer and the adult has waited the important five seconds, they can say "That was a hard one. We'll come back to that one" and then go back to CDI skills. The five seconds is a critical time, as adults often rapid-fire questions at children in general and this is even more stressful for children with selective mutism. The five seconds really gives the child the opportunity to respond and this patience shows the child that the adult is willing to wait for them to think about their answer and prepare to talk. If the child does not answer the question verbally but instead just nods his or her head "yes" or "no", the adult would say, "I see you nodding your head" or "I see your shaking your head no." Afterwards the adult would repeat the given question, but maybe with a twist. For example, if the first question was "Is this red or blue?" then the adult could say the question a second time as, "Is this red, blue, or something else?" giving the child another choice. Giving

them a choice such as "you don't know" or "something else" sometimes helps the child choose that answer if they are nervous about choosing. When the child first starts practicing answering questions, it is important for the adult to choose easy forced-choice questions that have obvious answers, such as asking the color of a toy in front of the child.

Other ways to get the child excited about answering questions is using questions that are related to the child's play. For example, if the child is playing with a toy car, the adult can ask, "Is that car going to go fast or slow?" This may increase the chances the child answers, since it is directly what he or she is doing. Often children with selective mutism may have an easier time answering forced-choice questions but a much more challenging time answering open-ended questions. Once the child is comfortable answering forced-choice questions, the adult can practice open-ended ones. Another skill that is taught to parents during the VDI training is how to prompt the child to talk. Direct prompts ask the child to verbalize a certain way but do not leave room for the child to be confused (Kurtz, 2008). This is usually a goal that is used later on when the child has already practiced VDI with new adults. When practicing in other settings, the adult may prompt the child "Go ahead and tell Sally if you want water or apple juice." This direct prompt is actually less anxiety provoking than saying, "Why don't we tell Sally what type of juice you want?" The direction and structure is comforting to the child.

An aspect of VDI that was not described yet is the brave talking sheet. Often clinicians make brave talking sheets for parents or new individuals in the child's life to use as reinforcement. An example of a generic brave taking sheet can be seen below.

BRAVE TALKING SHEET

The characters and colors used on the brave sheet are chosen by the child, so that they know this sheet is very specific to them. Receiving checks in the boxes are used as an incentive to practice brave talking. Each time the child verbalizes, the adult may give them a check on the sheet. The sheet can also be used for higher level goals, such as asking questions yourself or reading in front of a whole group. Depending on the child and their goals, the child receives a prize per sheet they fill out or per multiple sheets they fill out. Prizes usually start out as tangible, such as small toys. Later, prizes may include special privileges at home or activities to do with their family. At Child Mind, clinicians have these reinforcements (prizes) that children can earn after sessions.

The adult is also instructed to continue to use a heavy amount of labeled praise, reflections, and description throughout VDI as well as CDI. Whenever the child talks, the labeled praise should be very specific to the child talking. An example of this is saying, "Thank you for telling me. I love to hear your brave voice!" or "I love the way you asked for help!" Reflections should be repeated in a full volume so that the child's verbalizations are heard to everyone

around, even if the child just whispered. After an adult asks a child a question, it is important to go back to CDI skills afterwards to give the child a break after his or her bravery. Description is a really good skill to use here as well, just to ensure the child feels they are being accepted in their play or whatever else they are doing.

After parents practice CDI and VDI with their children, the next step is to practice "fade ins" with new people. In this section, the child begins to practice their brave talking with new individuals. Just like in the baseline, when the first confederate was faded in, this process happens again. A new individual will come into the room, introduce themselves, and say they will just be in the corner doing some work. After the child continues answering questions to the parent with the confederate in the room, the child will join the parent in play and stay in CDI. The parent will later slowly be faded out of the room. The goal is ultimately for the child to be vocal with the new individual without the parent there. The confederate starts in CDI with the child just following their lead. Once the child appears comfortable, the confederate will ask a forced-choice question to the child, making sure to wait 5 seconds and to praise if the child answers. They will also give the child checks on their brave talking sheet. This process is continued with as many new individuals as possible. After the child is comfortable in all these different scenarios, the clinician may choose to take the child on a scavenger hunt around the office or a "find a person who" hunt around the office. A scavenger hunt requires the child to say whatever they find in a loud voice as they go. A "find a person who" hunt requires a child to ask questions to different people in the office such as, "Do you have a dog?" or "Do you have siblings?" They also practice greeting the person in the beginning of the conversation and saying "bye" at the end. This is done through heavy prompt and reinforcement from the clinician. The clinician may say, "When we are leaving a person should we say 'Merry Christmas' or "Goodbye!" hopefully leading the child to say "Goodbye!"

The next steps in the therapy are to practice outside the office. The clinician may take the child on an "outing" and help parents practice their CDI and VDI skills in real day to day activities, such as going to a pharmacy or toy store. Clinicians also often go to the child's school to train the child's teachers on selective mutism, giving psychoeducation and helping them learn the skills that the parents have been using. The clinician and/or the parent will also lead a "fade in" with the child's main teacher and then with other teachers the child attends school with. This fade in process is very similar to the fade in that was done at Child Mind, but abbreviated to fit the teacher's schedule. The teacher will also start in CDI and then use VDI with heavy praise if the child begins to verbalize. This process is usually done at the beginning of the school day when there are no other children around yet and only lasts around 5-7 minutes. The teachers may also continue to use the brave talking sheet throughout the day and hopefully the fade-ins continue to other teachers throughout the school. The first few fade-ins are not always successful, especially since the school is often already "contaminated" but with additional support hopefully overtime it will help the child become comfortable. Personally, I have gone in to work as a one-to-one support with children with selective mutism at school and have helped teachers with this fade in process and prompting the child throughout the day. I have also worked to slowly increase goals the child can work on. For example, in the beginning I may work with the child to brave talk with their best friend. Later, I may increase the goal of speaking to 3 kids and the main teacher.

Overall, a summary of some of the tips the Child Mind Institute has given to families and teachers helping children with SM, which have been described previously, are to, "wait 5 seconds, use labeled praise, rephrase your question, practice echoing, and be a sportscaster," (Child Mind Institute, 2018). It is also important to emphasize that the Child Mind Institute does not push the child with SM to speak but rather the pace of treatment is gradual. The child is

prompted to speak and each small success is positively reinforced. The gradual progression of therapy enables the child to feel successful and gain confidence in the process. As seen above, involving as many people as possible in the therapy will greatly influence how successful the treatment is overall and in generalizing to the child's day to day life.

Child Mind Institute's "Brave Buddies"

The Child Mind Institute also offers an intensive group behavioral treatment program for children with SM to work on their brave talking with other children practicing the same types of things. This program is aimed at children ages three to twelve and focuses on helping them practice speaking in school and other public places (Child Mind Institute, 2018). The program is offered for varying times, some of the programs are day long, others are three days long, and there is also a week long. The program is similar to a classroom-setting in the way the day is structured but offers the children a great amount of encouragement and positive reinforcement for practicing "brave talking."

During "Brave Buddies," each child is paired with a one-to-one trained counselor. These counselors are volunteers who are intensively trained in the CDI and VDI skills. I have been a counselor in this program multiple times. The counselors lead the children through classroom-like activities with prompts and positive reinforcement to help the children talk to their peers and engage in fun activities. Many children join the group at different stages, but all of them are working on being brave in settings with new kids and adults. Some children enter the group being able to engage in activities behaviorally but not verbally, while other children may be inhibited in even participating in the activity or making a simple decision like choosing a color of paper (they often also have social anxiety). Practicing making choices, choosing a classroom job, helping friends, eating lunch, and going to the bathroom are all activities that may be difficult for these children and are incorporated in the program.

The day includes morning meeting, a craft activity, meals, and small field trips during the longer sessions. Besides being structured like a school day, the program also incorporates practicing other activities that the children may have difficulty with and need practice in. They are usually theme based around the current season. For example, for the October Brave Buddies, the children practiced trick or treating with their peers around the office. This was an important activity to practice because when Halloween comes around and the children go trick or treating with their families, the children often freeze up at the front door. An example of a small field trip is going to "Sprinkles" the cupcake store near the CMI office. Children practice asking for their cupcake many times with their counselor and then get to practice in real life, with high levels of support and reinforcement. The counselors work on progressively increasing challenges to the children throughout the day, prompting them to use verbal responses first with forced-choice questions and then prompting peer-to-peer or spontaneous conversation. It is important to emphasize that the counselor tailors the student's specific plan to what they are working on with the clinician. Children start the program at varying stages, so the child who has done Brave Buddies twice before may be the morning meeting helper while another child may make huge gains by just separating from his or her family and sitting in the room with other children. While the children are at Brave Buddies, parents attend a "parent session" in another room for half the day. During this session, clinicians give parents psychoeducation about SM, discuss skills on working with SM, how to bring the process to the child's school, and answer questions. This is a critical part of the treatment, as it is important to include the "child's team" when working through this challenge. Before attending this program, many of the children go through lead-in sessions with CMI clinicians to practice talking to some strangers. Lead-ins are likely to improve a child's success in the program, as it gives the child extra practice and explains what the program will be like to them.

In addition to the "Brave Buddies" program, Child Mind Institute also offers a "targeted practice" group every Friday for patients already practicing their skills in sessions with clinicians. Targeted practice, similar to the Brave Buddies program, offers children the chance to practice alongside their peers. The targeted practice is only an hour long but also enables each child to have a one-to-one counselor prompting speech with other adults and children in the group. This practice is usually encouraged for children who have already made improvement through their sessions at the Child Mind and is also good practice before a full day of brave-talking in programs like Brave Buddies.

For older children, the clinician will make the activity more age appropriate. Depending on the child's severity, the clinician may play pass the question ball with an older child. The question ball is a beach ball with different "get to know you" questions on it. This way the child can practice answering questions about him or herself and also asking them. Adolescents and teenagers may have more of a social anxiety presentation and the plan may practice speaking to another person about their hobbies or practice eye contact. Other aspects of therapy may include using social stories to practice expectations about certain activities that may be anxiety invoking, such as fieldtrips or sports classes. There are also often exposure therapy sessions, where the child may practice putting their hair up in front of people, practice eating, writing in front of people, or going to the bathroom.

Cultural Implications

Since selective mutism is still widely unheard of and there are minimal clinics that specialize in the disorder around the world, many children and families come from near and far to see clinicians from the Child Mind Selective Mutism Department. For families that are traveling far distances to see clinicians at CMI, there is an intensive treatment service available

to families. In this service, patients are seen for multiple sessions in a day and several days a week (Child Mind Institute, 2018).

Throughout my time as a program assistant for CMI, I have helped with sessions with families from all over the world. I have been faded into sessions in person with patients from China, Australia, Egypt, New Zealand, and may others. I have also worked with children from all over America. Eliana Gil & Athena Drewes (2005) researched cultural issues in play therapy. While PCIT-SM is not play therapy and is a behavioral intervention, the therapy still starts out as child-directed and is deeply rooted in play in the beginning. There are different barriers that can come up for multicultural work, such as differing values about family, therapy, play, language, and others. Gil & Drewes (2005) explain, "The therapist needs to keep in mind how different cultures value the family, and how these values affect the use of play therapy. European American culture values privacy and autonomy, independence, self-care, and egalitarian ideals. In other cultures, family interdependence and family members; caring for each other predominate. 'Family' often includes not only the nuclear family, but also extended family members (especially older ones) and close friends," (p.75). This is a nice summary of values that are critical to think about in therapy and comes up in PCIT-SM.

When working with a family from China, the parents had questions regarding CDI and how to play with their child. They felt the therapy was unrealistic to the way they play at home and the times they believe their child needs to be practicing the skills. The therapy was tailored to the family's concerns and the practice was done around some educational toys and later incorporated homework while using the SM CDI and VDI skills. Gil & Drewes argue that, "Traditionally, Asian children are viewed as 'little adult.' They are expected to be well-behaved and hard working. Childhood is viewed as a preparation period for adulthood; therefore, working hard for academic performance and learning survival skills for real life are important," (p.182).

While these values are definitely not apparent for all Asian families, it is important to have a discussion with families before starting therapy and tailor the therapy in a way that it will generalize within the family's home structure. It is also important to be transparent about the therapy and ask the family personally what barriers they may expect to face. By being transparent and discussing the family's specific values, the child is more likely to succeed with the therapy and the family is more likely to follow "the plan." Another aspect of this therapy that was tailored based on cultural differences was how to "reflect" the child. This family was having a difficult time reflecting the child without asking a question. They would "tip-up" their reflection which is when the word ends on a higher note, making it seem like a question to the child. Typically, clinicians coach parents to realize these tip-ups and practice tipping-down their reflections. However, this family did not realize that their natural way of communicating was in this tip-up way, and for them they were not seeing it looked like a question. The clinician decided to do a specific skill drill on the tipping down to help the parents become more self-aware of when it was happening and how best to coach around it.

Another family I worked with came from Australia. This family had a very difficult time using positive reinforcement with the child and giving specific prompts. Many children with SM need prompts to get started on tasks, or to stand up in front of a group, or other skills they are working with. The parents discussed not being used to this type of speech, so the clinician focused the therapy on a lot of this work while also tailoring the positive reinforcement to be something that works in the family's culture. For example, they did not incorporate tangible awards but rather found "prizes" that the family would feel comfortable giving such as earning special time with mom or dad such as cooking together.

Chapter 3: Other Approaches

In this chapter, I will present a review of other approaches used to treat selective mutism. It will describe another behavioral therapy that is different from the one at The Child Mind Institute called The Social Communication Anxiety Treatment Plan (S-CAT). This section will also review a case study from psychodynamic therapy and pharmacological medication for SM.

Other Behavioral Therapy

I have worked extensively at the Child Mind Institute so their approach is the only one I know from direct experience. There are other types of behavioral intervention for selective mutism that have some differences in exact protocol, but also focus on helping a child become comfortable in the social environment and include CBT skills in them. The Selective Mutism Association's president Dr. Elisa Shipon-Blum came up with an evidence-based Social Communication Anxiety Treatment Plan called S-CAT. They describe this intervention as, "S-CAT provides choices to the child and helps to transfer the child's need for control into the strategies and interventions. Games and goals (based on age) are used to help develop social comfort and ultimately progress into speech via the use of ritualistic and controlled methods (e.g., strategy charts). Silent goals (environmental changes) and active goals (child directed goals based on choice and control) are used within the S-CAT program as well" (SMA, 2018). The important goals of S-CAT focus on reducing pressure to speak with the therapist in the beginning of therapy. For example, the child doesn't have to make eye contact and this hopefully will make them more comfortable. Another important aspect is reducing enabling behavior patterns in parents (Klein, Armstrong, Skira, & Gordon, 2016). The therapy focuses on "bridging" the gap between nonverbal gestures and verbal gestures, trying to give children an ability to communicate even when they are in between both of those. Klen et al. (2016) looked at the

accuracy of S-CAT and found that the majority of individuals exhibited higher levels of speaking after the therapy.

Moreover, Dr. Elisa Shipon-Blum came up with an intensive- group intervention similar to Brave Buddies that uses S-CAT skills. The name of this camp is Communicamp and takes children age 3-17. The group is also structured like a day at school and includes parent training throughout. The point of the camp is to instill social confidence in children with selective mustim, social anxiety, and social communication problems. Counselors in the program use S-CAT strategies for each camper's individual needs (SMA, 2018). Each counselor works with 2-3 children closely, giving them individualized support.

Psychodynamic Therapy

The psychodynamic intervention for selective mutism is most often the use of play therapy (Anstendig, 1998). The main research on this type of therapy is case studies. In this therapy, the child "takes control" over his or her play in order to come to terms with "their real self." The idea is that the child will solve their own problems with their own timing. Although this is not the most highly used treatment approach to selective mutism, or anxiety in general, case studies have shown potential benefits of this approach. Many early treatment approaches for selective mutism stemmed from psychodynamic theory and have focused on the origin of the disorder rather than the actual mutism (Cohan et al., 2016). Child-centered play therapy demonstrates the importance of giving control back to the child, really accepting them as they are, and letting them explore their own needs through play. It is critical in a child's sense of self and dealing with adversities that they may not understand or know how to explain. This type of therapy does not focus on the diagnosis of the child, but rather accepts the child as they are and gives them the autonomy to work through their concerns and need themselves (with the support of a therapist). The play therapy setting is free and non-judgmental.

Fernandez & Sugay (2016) described a case study of a 9-year-old-girl and the youngest child in a Filipino-Chinese family. This girl came to therapy because her family was aware that she would only speak to her immediate family members. She would not speak in school or public places. In the therapy, the patient was instructed she could play with whatever toys she wanted and the therapist followed her lead in play. The therapy consists of the therapist observing the type of play the patient was using and just letting the patient express her feeling through nonverbal gestures and play. Fernandez & Sugay (2016) explained that this therapy enabled the patient to, "communicate underlying situations, conflicts, and feelings through symbolic form, which psychodynamic theorists suggest hindered her from speaking." The result of this play therapy in this specific case study was that the patient began to communicate verbally over time. As she became comfortable communicating nonverbally with the therapist, this turned to communicating verbally through the toys and ultimately led to speaking in school. It is important to note that this was one specific case study on a particular child.

There have been some questions over the efficacy of play therapy for selective mutism. With free play, the child often feels safe and enjoys the therapy, but they are not being challenged to verbalize or practice their fears. It is very difficult to get a child to speak about their fears without being prompted or asked to. Shipon-Blum (2007) explains that "psychological approaches are effective only when all pressure for verbalization is removed and emphasis is placed on helping the child relax and open up. When pressure to verbalize is reduced, anxiety decreases and therapeutic interventions can subsequently occur."(p.6). However, if the therapist just asked the child to speak about their fears, this would probably lead the child to freeze up in the play. While this type of treatment is rarely the primary mode of treatment for children with SM, this type of therapy is often used in conjunction with behavioral therapy. Other therapies that are used in conjunction with behavioral therapy include music and art therapy.

While behavioral treatment is the go-to treatment for selective mutism, some children require more assistance through medication. Clinicians most often suggest behavioral therapy for the selective mutism first, and if the child does not make significant improvements after a month, medication consultation may be the next step (Child Mind Institute, 2018). However, it is important to remember that if clinicians decide to recommend medication, the behavioral therapy should still be continued at the same time. While medication may help a child become more comfortable in a social environment and more open to therapy, the critical social skills are taught through therapy.

Typically, a child psychiatrist will prescribe an antidepressant medication such as SSRIs. SSRIs (Selective Serotonin Reuptake Inhibitors) have been largely effective for anxiety disorders like SM. The Child Mind Institute (2018) states, "This medication takes several weeks to work and therefore can help children slowly become less inhibited and more able to participate in therapy over the long-term." It is important to note that psychotherapy is the preferred initial treatment, as well as support for family and teachers. However, only when a child does not respond to psychotherapy, additional pharmacologic treatment should be considered (Kaakeh & Stumpf, 2008). The age children typically begin medication is roughly 7-8, although sometimes children begin medication earlier if their symptoms are extreme (Child Mind Institute, 2018). Fluoxetine is the most studied SSRI treatment for selective mutism, although more research needs to be done. In one report, SSRIs were effective in 11 (65%) of 17 children with selective mutism according to parent assessment (Schwartz, Freedy, & Sheridan, (2006). In another study of fluoxetine for selective mutism, 21 children (ages 5-14) showed statistically significant improvements while also pursuing psychotherapy. The exact reason SSRIs may improve selective mutism symptoms is unknown, although Kaakeh & Stumpfy believe it may be, "an

underlying imbalance in central nervous system serotonin that is corrected by SSRI therapy,"
(p.218). Studies of fluoxetine and children with selective mutism have mainly been smaller
sample sizes but have demonstrated improvement in symptoms (Kaakeh & Stumpf, 2008). There
is some concern about not having a great amount of research on long-term effects of SSRIs, but
from what has been seen it has been a relatively safe drug especially with its success in many
other childhood psychiatric disorders.

Chapter 4: Discussion

In the discussion section, I will discuss challenges in selective mutism assessment and the importance of early intervention. This section will also go on to describe future implications of this work and skills teachers and parents can use even before the child begins therapy. Overall, I make the argument that there needs to be more support for parents and teachers regarding selective mutism and anxiety in general.

Assessment Limitations

There have also been different articles that have discussed the potential difficulty in assessing children with selective mutism in academics and learning disabilities. Evelyn Klein and Sharon Armstrong have done extensive research in these domains. In Klein, Armstrong, and Shipon-Blum's (2012) study, they tried to find valid assessments for 33 children with SM and also discussed the barriers during this process. They cite Chomsky (1965) in *Aspects of the Theory of Syntax* explaining that, "communication *competence* refers to people's knowledge of their language and their ability to use it under ideal circumstances, whereas communication *performance* refers to people's actual use of their language ability, which may be affected by contexts and internal states accompanying a speech event (e.g., states of fatigue, emotional arousal, or anxiety)." This idea is important when thinking about trying to assess a child with selective mutism or anxiety. It is important to figure out whether the language difficulty is due to a lack of language competence or whether there is a performance inability. Klein, Armstrong, and Shipon-Blum (2012) specifically argue that assessing language competence in children with SM is incredibly difficult for teachers and other professionals, because the child is unlikely to speak to them without specific fade-ins or through therapy work.

While one of the misconceptions that was discussed in this paper was that children with SM have communication problems, Sharp et al. (2007) actually found that language related

difficulties are a significant risk factor for the development of SM. While the DSM clearly states that children with SM typically have "normal" language skills, many children may also have a comorbid diagnosis with communication disorders. Klein, Armstrong, and Shipon-Blum's (2012) study tried to look at receptive and expressive vocabulary in children with SM, as well as looking at the efficacy of having parents deliver academic tests to their children since they are not speaking to the educational professionals. They found that children performed significantly better when the tests were performed by their parents rather than professionals. Therefore, language competence in SM is more accurately depicted by family members administrating the tests (Klein, Armstrong, Shipon-Blum, 2012).

Moreover, Klein, Armstrong, Shipon-Blum (2012) also found interesting results regarding the language competence tests that were given by families to children with SM. They state, "Although children scored similarly on the receptive (pointing) and expressive (naming) vocabulary tests, a decrease was observed as the narrative tasks changed from narrative comprehension (answering questions about a story read to them) to oral narration (telling a story on their own)" (p.9). There was a difference between children with SM's ability to give a one-word answer compared to formulating many sentences (which was more difficult). There was a significant difference seen when children with SM were asked to recall a story rather than just answer a question. This study suggests that while not all children with SM have language deficits, many may not have full expressive language ability. Children also often have anxiety around these apparent deficits and therefore are more comfortable answering spontaneous questions (especially at home) rather than decision or open-ended questions (often at school) (Klein, Armstrong, Shipon-Blum, 2012). This study also brings up the future need for more SM assessment to be done by parents rather than teachers, hopefully to gain a better understanding of the language difficulties that a child may be having. If these assessments are more accurate, the

therapy can be more specific to the child's needs and these language deficits can be pinpointed earlier on.

Early Intervention

Early intervention is critical to treating selective mutism. In order for early intervention to be a possibility for more families, the first step is education about what selective mutism looks like and what to do when you start to see symptoms in your child. Dr. Shipon-Blum (2007) explains, "The earlier a child is treated for selective mutism, the quicker the response to treatment and the better the overall prognosis. If a child remains mute for many years, his or her behavior can become a conditioned response where the child literally becomes accustomed to nonverbalization as a way of life" (p. 5). This is when the cycle of negative reinforcement begins. The longer the negative reinforcement cycle continues, and if it continues with more adults and more environments, the trickier treatment will be in the future. Shipon-Blum (2007) also states that "if selective mutism is left untreated, the academic, social, and emotional repercussions may include depression, social isolation, poor academic performance, self-medication with drugs and alcohol, and suicide," (p.5).

Psychotherapy should be the first step when one believes their child may have symptoms of selective mutism. A baseline observation is critical in order to create a treatment plan that is specific to the child if the diagnosis is selective mutism. Behavioral intervention is the leading treatment for selective mutism, but can be coupled with different therapy methods as well as medication if needed. Group work is critical in a child's success in overcoming selective mutism as the disorder is rooted in anxiety in the expectation to speak. Children should practice in small groups in order to later be able to feel more confident and comfortable in other social environments such as their schools.

Another important aspect of selective mutism therapy that was highlighted in this thesis was the importance of working with the child's team. Family training and support is critical in therapy. The parents often feel a large amount of anxiety themselves and are adding to the negative reinforcement cycle of their child's SM without realizing it. Including the whole family in therapy will help alleviate anxiety symptoms for both child and parents, as well as make the therapy more effective. Children are also typically most comfortable around their parents and speak at home, so it is important to start therapy where the child does feel most confident. Parents should also continue to use the skills they learn in therapy at home, so children are consistently practicing. Moreover, the teachers are another greatly important part of the child's team. Children spend most of their days in school and this is more often the "contaminated" environment for children with selective mutism. "Fade in's" with teachers are an important part of the behavioral therapy for children with SM, as well as just psychoeducation in general about what anxiety is and how to tell if children in the classroom may have it. Children with selective mutism may easily not be noticed, especially in the early stages of school, as they are often respectful and still finishing their school tasks. It is important to help teachers look out for these symptoms and give them tools they may use when confronting children that appear to have this anxiety.

Future Directions

In terms of future directions, through my own experience I have noticed that there are many more resources across diverse environments for teachers to receive psychoeducation and coaching around behaviors such as ADHD and other behavioral problems. However, there are many fewer resources for psychoeducation around anxiety. This is because children who are anxious often slip through the cracks while the children with behavioral problems are very obvious in the classroom. I have gone into schools to work as one-to-one support with children

with selective mutism and seen them make huge strides with support in breaking down their challenges and prompting. These children have gone through behavioral treatment at the Child Mind Institute, but needed support in having the services generalize in school. I would work with both the children and the teachers in skill-building. Teachers are very busy trying to manage full classes, so one-to-one support drastically helps ensure the child is receiving prompting and support throughout the day. However, at the same time one-to-one support is expensive, time consuming, and there is a lack in counselors who are trained and able to do this. Therefore, it would be important to bring more resources to train teachers with small skills they can use for children with selective mutism and anxiety in general. If teachers would be able to have a few days of training with these skills and support learning how a five minute fade-in can look, they would be able to strengthen the work the child is doing in therapy. Some training for teachers will help them support children with selective mutism even if the child is not in therapy. Regardless the child should pursue therapy, but if teachers know how to conduct fade-ins, the child may be more likely to feel comfortable starting to talk. Since early intervention is critical, teachers can start to decrease the reinforcement cycle by using basic skills when they notice a child has selective mutism or anxiety in general.

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