CLD Corner: Selective Mutism and the CLD Child

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The CLD Corner was created in an effort to provide information and respond to questions on cultural and linguistic diversity. Questions are answered by members of the TSHA Committee on Cultural and Linguistic Diversity (CLD). Members for the 2016-2017 year include ***Raúl Prezas****, PhD, CCC-SLP (co-chair);* ***Phuong Lien Palafox****, MS, CCC-SLP (co-chair);* ***Mary Bauman-Forkner****, MS, CCC-SLP;* ***Alisa Baron****, MA, CCC-SLP;* ***Judy Martinez Villarreal****, MS, CCC-SLP;* ***Irmgard Payne****, MS, CCC-SLP;* ***Lisa Rukovena****, MA, CCC-SLP;* ***Mirza J. Lugo-Neris****, PhD, CCC-SLP; and* ***Andrea Hughes****, MS, CCC-SLP. Submit your questions to TSHACLD@gmail.com, and look for responses from the CLD Committee on TSHA's website and in the* Communicologist*.*

I walked into a therapy room and saw a 12-year-old boy. He was looking at his hands, rigid and uncomfortable in his chair. He had a flat affect and responded to questions with a nod or shake of his head, never making eye contact. At school, he never spoke, and sometimes his teachers marked him absent because he didn't verbalize his presence. At home, however, he talked up a storm in Spanish with his mother and his four younger siblings. This was my first experience as a master's student working with a child with selective mutism (SM).

Fast-forward to a year and a half later, and I was a clinical fellow getting the opportunity to work with this young man (now a teenager) again. He was speaking in quiet and short, full sentences. He didn't look directly into my eyes but looked at my forehead or nose when he spoke. And when I said something funny, I even got him to crack an occasional smile. Although he continued to remain silent at school, he was making progress.

Selective mutism is characterized by a refusal to speak in specific social settings despite the ability to speak in other settings (American Psychiatric Association, 2013). The extent to which a selectively mute child speaks in different contexts varies (Freedman, Garcia, Miller, Dow, & Leonard, 2004), and SM symptoms fall along a continuum of severity (Schwartz & Shipon-Blum, 2005). Children with SM often do not speak loudly in public, and there is typically a hierarchy of people with whom the child speaks (Freeman et al., 2004). Children with mild SM usually communicate with only family and a select group of friends. They use gestures in settings where they are less comfortable. Children with moderate SM communicate using sounds but not whole words, and children with moderately severe SM only use nonverbal gestures. Lastly, children with severe SM do not communicate verbally or nonverbally.

Language minority and immigrant children are at higher risk of SM than native-born populations (Elizur & Perednik, 2003; Toppelberg, Tabors, Coggins, Lum, & Burger, 2005). There are transcultural challenges involved in diagnosing SM in language minority and immigrant children (Toppelberg et al., 2005; Elizur & Perednik, 2003). Learning a second language takes time, and it is often unclear if a child who otherwise meets other criteria for SM has achieved the right level of linguistic knowledge or familiarity to qualify for such a diagnosis. The nonverbal or "silent" period is a frequent and normal stage of second language acquisition in young children (Toppelberg et al., 2005). It typically starts when children realize that their home language is not understood at school, and their second language skills are insufficient or absent. They then stop speaking completely in that setting. Observations suggest that the nonverbal period is typically shorter than six months, common in 3- to 8 year-olds, and longer in the younger child (Tabors, 1997). Although children going through the silent period will become more verbal with time, children with true SM display no progression.

Early diagnosis is important because language minority children are more likely to be underserved (Hernandez et al., 1998). SM often hinders social functioning, second language acquisition, and educational achievement (Manassis et al., 2003) and may predict current or emergent anxiety disorders (Kristensen, 2000; Rosenbaum et al., 1993).

Shy, anxious, and/or inhibited children expected to function in a second, unfamiliar language may be more prone to reacting with mutism. When this mutism becomes severe and prolonged enough, it warrants the diagnosis of SM. Bilingual children with true SM present with mutism in both languages, in several unfamiliar settings, and for significant periods of time. In contrast, the child with typical development in the nonverbal period typically presents with mutism in one language, in one or two settings, and for only few months. Most children learning a second language, despite substantial language exposure, will not feel fully comfortable in the second language in six or more months. Language delays can affect the learning of a second language and are common in children with SM. Potential language delays that predispose children to SM should be assessed by a bilingual speech-language pathologist (SLP) and should include phonology, morphosyntax, semantics, and pragmatics subtests (Toppelberg and Shapiro, 2000) in both languages. New methods for the assessment of language function in children with SM have been developed (Manassis et al., 2003). In an assessment, Manassis et al. (2003) also recommend adding a standardized rating scale of child psychopathology, the Selective Mutism Questionnaire (SMQ; Bergman et al., 2001), or the School Speech Questionnaire (SSQ), a modified version of the SMQ.

Interventions

Once an evaluation reveals that a child requires services, selecting an appropriate intervention plan is important. A meta-analysis of psychosocial interventions for children reviewed 23 studies, and the authors found that the use of behavioral and cognitive-behavioral interventions was most effective for children with SM (Cohan et al., 2006).

Behavioral interventions with combinations of contingency management, shaping, stimulus fading, social skills training, and self-modeling techniques have all been effective. An effective behavioral intervention should include a slow, systematic program that rewards approximations of target behaviors. The goal of therapy should be the ability of the child to have normal social interactions in all communication contexts. Attempts at improved communication in school and therapy settings should be reinforced, including verbal and nonverbal attempts (appropriate eye contact, gesturing, nodding, nonverbal participation in group activities). As the child learns skills to manage his or her anxiety (through relaxation training, cognitive restructuring, and exposure exercises), he or she should be reinforced for more difficult communicative contexts.

Cognitive behavioral approaches that include cognitive processing, relaxation training, and systematic desensitization are also effective interventions. Shaping and stimulus fading techniques appear to work well in school settings, while systematic desensitization may be used in individual therapy sessions to help the child learn to manage his or her anxiety in feared social situations.

Treatment Options for Children with SM

1. **Desensitization hierarchy**: Help the child rate feelings of being scared or uncomfortable and determine where it is easiest to communicate and where it is the most difficult. In therapy, the SLP works with the child to practice speaking in each situation until the child feels comfortable at each step of the hierarchy to move on to the next step. When comfort is reached in individual sessions, the hierarchy can be transferred to the school setting. This can include inviting classmates to a place the child is comfortable speaking and then progressing to meeting on school grounds and eventually in the classroom.
2. **Contingency management**: This involves the administration of positive reinforcement contingent upon verbalization. Often reinforcement is provided for initial approximations to communicative behavior, like pointing or nodding, and continued until shaped into the desired outcome (verbalization) (Amari, Slifer, Gerson, Schenck, & Kane, 1999).
3. **Stimulus fading**: Stimulus fading consists of sequentially increasing (fading in) the number of people present when the child is talking. Sessions can start with rewarding the child for speaking to the SLP and then build to speaking in the presence of one stranger, then two, and so on, all the while reinforcing the child for speaking. Each new person gradually comes

closer and closer to the child until seated at the same table with the child. The process can continue until the child is speaking in front of a group of people.

4. **Self-modeling**: The SLP can audio/video record the child and edit the tape to show him/her speaking in settings where the child does not speak, like the classroom. The clip serves as the “feared stimuli” in an exposure paradigm. During treatment sessions, the child, in the company of others, watches and listens to him/herself speaking. Across sessions, habituation to the fear of others hearing the child speak occurs, thus allowing the child to speak normally in front of others (Kehle, Madaus, Baratta, & Bray, 1998).

For more information on SM, please visit the American Speech-Language-Hearing Association (ASHA) website (www.asha.org) and these resources: When a Child Goes Silent (*ASHA Leader*, http://leader.pubs.asha.org/article.aspx?articleid=1921108) and Selective Mutism (ASHA Practice Portal, http://www.asha.org/PRPSpecificTopic.aspx?folderid=8589942812&section=References).

In summary, SM in language minority children learning a second language can be suspected when mutism is prolonged, disproportionate to second language knowledge and exposure, is present in both languages, and frequently concurrent with shy, anxious, or inhibited behavior. Intervention strategies are available; however, treatment plans should be prepared in relation to each individual child’s needs.

Note: The intent of this article is not to infer that SLPs are the only ones who diagnose and treat selective mutism but rather to provide guidance on the treatment of selective mutism in CLD populations for clinicians, educators, and family members of those affected.

The most recent *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5, 2013) describes selective mutism to be an anxiety-based disorder and recommended treatment outcomes include a team-based approach with a psychiatrist, psychologist, or counselor in addition to a SLP. ASHA also supports this multidisciplinary approach and states we should be part of a team that would include the pediatrician, the SLP, the psychiatrist or psychologist, teachers, parent, and the individual (ASHA, 2017). In many public school districts, SLPs typically work with students with SM as part of a collaborative team that is headed up by a licensed specialist in school psychology. By working with the student alone, we would likely be ignoring a significant aspect or perhaps etiology of the disorder, such as anxiety or other mental health issues that fall outside the scope of practice for speech-language pathology.

Alisa Baron is a practicing bilingual speech-language pathologist and doctoral student at the University of Texas at Austin. Her primary clinical and research interests lie in bilingual language development and language impairment. She is particularly interested in language processing of bilingual children with and without language impairment so that more intervention techniques can be created and improved upon for this growing population.

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