Parents Supporting Children with Selective Mutism: A Treatment Group

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Abstract

The purpose of this project is to describe selective mutism (SM), identification, assessment, interventions, and treatment to provide a basis for the development of a psychoeducational group for parents of and children with selective mutism. This paper will provide a background on the etiology and treatment of SM for the purposes of forming a treatment group for parents and children with selective mutism.
Parents Supporting Children with Selective Mutism: A Treatment Group

According to the *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition, Text Revision* (DSM-IV-TR) (American Psychiatric Association, 2000), selective mutism is a rare childhood disorder that affects fewer than 1% of people seen in a mental health setting and which is characterized by a persistent failure to speak in social situations, most likely due to social anxiety (Sharkey, Nicholas, Barry, Begley, & Ahern, 2008). Research shows that early intervention is the key to helping children with any disorder and SM is no exception. While parents may not be able to prevent children from the development of SM, therapists have the power and the responsibility to educate and provide therapeutic resources for families and children to succeed. Parents are often left with few resources for SM most likely due to its rarity. Diagnosis and treatment can be difficult. Group therapy for SM may provide an additional effective means to treat the individual and provide a social environment within which both the child and parent can practice techniques with support from therapist who specialize in SM.

Groups meet weekly for 10 weeks with components for both parents and children. Because the group is psychoeducational and contains therapeutic support for parents and children, it focuses on helping parents become educated about selective mutism (SM), support for each other through their experiences, and providing techniques for working with their children. The work with children focuses on interventions based on cognitive behavioral therapy (CBT) and behavioral techniques, Adlerian concepts, social skill building, and self-regulatory techniques. The work with parents focuses on the same CBT skills, Adlerian concepts as related to working with children, the purposes of behavior, and encouragement. The group meets with parents first, during which time the children work on building social and behavioral skills as well as other therapeutic components.
Selective Mutism

Selective mutism is essentially the failure to speak in social situations while having the ability to speak normally at home. According to the DSM-IV-TR (APA, 2000), SM is described as follows:

- Consistent failure to speak in specific social situations (in which there is an expectation for speaking, e.g. school), despite speaking in other situations.
- The disturbance interferes with education or occupational achievement or with social communications.
- The duration of the disturbance is at least 1 month (not limited to the first month of school).
- The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language acquired in the social situation.
- The disturbance is not better accounted for by a communication disorder (e.g. stuttering) and does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder (p. 127).

Characteristics

Selective Mutism can be difficult to diagnose. In extreme cases, several characteristics may be present: extreme shyness, embarrassment, anxiety in social situations, severe impairment in social and school functioning, panic attacks, withdrawal, impulsivity, negativism, temper tantrums, sensory integration issues, clinginess, controlling, or oppositional behavior (Giddan, Ross, Sechler, & Becker, 1997). While not all of these characteristics must be present, many exist in the child with SM. This disorder does not consist of incompetence or difficulty with the language, a language barrier, or speech/language problems such as Apraxia (Moldan, 2005).
Classification

There is still some debate as to how the disorder should be classified. Currently in the *DSM-IV-TR*, SM is classified under “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence” (APA, 2000, p. 125). Etiological theories are varied and some link SM to anxiety, more specifically social anxiety/phobia. Other theories link SM to social phobia (Sharp, Sherman, & Gross, 2007). SM may also be co-morbid with other disorders and is more common in girls than boys (Crundwell, 2006). It is unclear which comes first, the Selective Mutism or the anxiety. However, given the current research, it appears that anxiety may be the first onset toward becoming selectively mute.

While the onset of SM occurs most commonly around 3-5 years, research shows SM usually is noticed in the preschool years when the child first goes to school and is unable to communicate with teachers and peers. The *DSM-IV-TR* (APA, 2000) states that the onset age of SM is before age 5. Children who have SM often are not identified at this age, and it is not brought to the attention of teachers and parents until the child begins school at which point the she ceases communication in social settings outside the home. Because the parents have witnessed extreme shyness, social anxiety, or withdrawal possibly only when out in the community or at social gatherings, the seriousness or level of impairment may not have presented itself (Moldan, 2005).

While there may be several symptoms of SM, some of these may be witnessed only at home and others only out in public. Many people will not believe parents when they explain that their child is “normal” at home. The discrepancy between the public and private social behaviors can create difficulty not only for parents but also professional clinicians during assessment, diagnosis, and treatment. Case studies and research show how professionals have found great
difficulty in communicating with the child with SM. Other people in contact with the child with whom she is not familiar may find the child defiant, disrespectful, unsociable, and rude which can lead to false or misdiagnosis. These children risk being stigmatized and ostracized by peers because of their lack of social skills (McInnes & Manassis, 2005).

The child with SM will cease social and communicative behaviors when out in public and may lack typical social interaction skills. She may be loud, bossy, talkative, imaginative, and noisy when with parents and siblings. Occasionally, the child with SM may exhibit more intense reactions and sensory integration difficulties than the average child. For example, she may be overly silly, excitable, reactive, and aggressive (Moldan, 2005; Crundwell, 2006). The child may also have difficulties with textures, tastes, smells, and sounds. Out in public, the child may gesture, nod, use non-verbal communication, and avoid eye contact (Crundwell, 2006). She may whisper to parents or just become completely silent as anxiety takes over her. Crundwell (2006) believes that significantly high levels of anxiety inhibit the inability to speak, not oppositional behavior or manipulation.

Function

What is the function of Selective Mutism? Moldan (2005) states that SM is a self-regulatory means to control emotions and behaviors. By becoming selectively mute, the child is able to control her anxiety and fear. She is negatively reinforced by the discontinued social interaction. In essence, something aversive (the social interaction) ends by the child becoming selectively mute (to decrease anxiety), and so the behavior is more likely to continue and increase while coping with any uncomfortable social situation. From a behaviorist perspective, the function of the behavior might be seen as escape and/or avoidance of an undesirable situation. The function of the behavior might also be to self-regulate emotions or to cope with
internal anxiety. Both perspectives and functions help to better explain the behavior of the selectively mute child. A treatment plan can begin by identifying these functions. Therapy may include these functions to identify an effective, ethical, and socially responsive replacement behavior.

**Psychotherapy and Selective Mutism**

**Theories of Psychotherapy**

There are several aspects of psychotherapy that have been useful in helping children with SM and their families. Kratochwill et al. (2002) identified four types of treatment models used for SM. They found that behaviorally-oriented treatment is better than no treatment. The research suggested four types of treatment models used with SM: psychodynamic, family systems therapy, behavioral, and biological approaches. Most common among research are behavior therapy and multimodal interventions, which can be incorporated into a group therapy model for the purpose of teaching parents and providing therapy for children in a social context.

**Psychodynamic Therapy**

The psychodynamic approach combines the medical model with biological and psychoanalytic theory. The main components of this theory combine communicative interactions and art or play therapy to determine the unconscious problems which lead to emergence of problematic behaviors (Kratochwill, 2002). When the therapist is able to identify these problems, the behavior may cease to exist. In regard to SM, the psychodynamic therapist seeks to find the underlying cause of the mutism. There are a number of possibilities that range from punishing parents, maintaining secrets, hostility, or regression. Art or play therapy are very systematic forms of therapy in which the child is allowed to bring forth subconscious issues through primarily nonverbal play. Kottman and Warlick (1989) describe Adlerian play therapy as a
method to incorporate principles of encouragement, family constellation, early recollections, and goal disclosure as a way to develop insight and develop alternative coping mechanisms. For example, during the reorientation phase the therapist can help the child generate alternative behaviors and interactions with encouragement (1989). The Adlerian therapist can provide parents with new ways to relate to the child.

**Family Systems Therapy**

Family systems therapy involves all members of the family. The therapy goal is to help the family at a systemic level. Because the family is the social context for the child, therapy seeks to treat the family as a unit. For the child with selective mutism, the focus of therapy is to modify the communication and interactions within the family (Kratochwill et al., 2002). The therapist will work to mend the communication within the family among the individuals and toward the child with SM as well as making interactions more successful for the family system. Berry (1983) describes how the Adlerian family therapist may provide interventions based on strengths for working with the family, ways to encourage parents, guidance and modeling for children.

**Behavior Therapy**

Behavior therapy is based on modifying behavior through looking at antecedents, consequences, and reinforcers. By looking at the environment, the therapist is able to identify when and where the behavior occurs. In regards to identification, assessment, and treatment of the child with SM, direct observation of the child across settings must occur. From this, the therapist is able to identify what maintains the muteness. Then, the therapist manipulates the environment and conditions to identify precursors and treat the child.
The four models used within the behavior therapy are neobehavioristic, applied behavioral analysis, social learning theory, and cognitive behavior therapy (Kratochwill et al., 2002). The neobehavioristic model identifies the stimulus-response and techniques such as systematic desensitization are utilized. This might look like the following: a child with SM is exposed to anxiety provoking situations gradually while relaxed, so as to desensitize the child from anxiety. Relaxation skills may be taught to coincide with more anxiety-producing stimuli. Applied behavioral analysis, within which a functional behavioral assessment can be conducted, may include techniques such as positive reinforcement and extinction of the behavior. Social learning theory applies social skills training within a social environmental context. Cognitive behavior therapy (CBT) seeks to internally change the thoughts in an effort to modify behavior. In most research to date, CBT is one of the most effective forms of treatment of SM within a multimodal approach. Behavior therapy could be easily incorporated into child group therapy during sessions when children and parents are separated.

**Identification and Assessment**

If a child is suspected to have SM, referrals to professionals are common. Most commonly, the school psychologist, family physician, psychologist, or psychiatrist would make the formal diagnosis. Cohan, Chavira, and Stein (2006) found that primary care practitioners often misdiagnose children with SM, or provide improper referrals for treatment. Because primary care physicians may often be the first professional consulted, parents may unfortunately be lead astray. Assessments should be completed by mental health professionals in order to provide the proper diagnosis. A complete medical exam, developmental history, observations, behavior checklists, and formal checklists/tests can be administered (Crundwell, 2006).
Kearney and Vecchio (2007) came up with a set of questions to assess the disorder which may help both parents and teachers: 1) What specific settings involve failure to speak? 2) Has the mutism lasted at least one month? 3) Does the child speak well at home with people she knows well? 4) Is failure to speak significantly interfering with the child’s academic or social development? 5) What circumstances surround each episode of mutism? 6) Can the child be encouraged to speak audibly in any way in certain public settings? 7) How do others respond to, or compensate for, the child’s mutism? 8) Does the child appear anxious or depressed in situations involving mutism? Mental health professionals are best equipped to assess and identify SM; however, this questionnaire is a beginning point for parents and teachers to come to the referral process.

While research shows that early identification is critical in the success of treating the child with Selective Mutism, it can be very difficult to assess, diagnose and treat. The silence of the child with SM not only decreases the ability to assess her but also the ability to provide accurate assessment. Because it is a rare and relatively unknown disorder, practitioners may have little to no exposure or knowledge of SM. Often times, the child may be diagnosed with a few other disorders before Selective Mutism is realized.

**Interventions and Treatment**

Sharp, Sherman, and Gross (2007) suggest mental health professionals must increase awareness for the best success of the SM child. This is done by bringing to light common symptoms and signs of the disorder. Common interventions include: a multidisciplinary team approach, transfer and shaping, reward systems, behavioral observations and logs, increasing conversational opportunities, and monitoring/evaluating interventions. Crundwell (2006) suggests school-based interventions with the selectively mute child, which can easily be
transferred to the social skill building portion of group therapy. The steps are: transfer speech to activities, locations, and individuals through gradual steps (fading); build rewards and encourage the child so speech can become less anxiety-provoking; increase group conversational opportunities with peers; and monitor and evaluate intervention techniques to ensure success.

Another intervention that could be used in group therapy would be speech transfer and shaping: allowing the child to first begin talking to the therapist, and eventually others. Speech transfer refers to talking within one setting and then transferring the communication to other settings (Crundwell, 2006; Giddan et al., 2007). Transfer and shaping refer to increasing the speech to new activities, locations, and peers, transferring speech to where it did not previously occur. The goal is to gradually get the child comfortable and able to talk to more people in more settings. Parents would be taught these skills in the parent psychoeducation group so as to build and expand the child’s opportunities for speaking and success. Once the speech is apparent, fading out the reinforcements and prompts can occur when the child speaks with various individuals.

Other behavioral treatment techniques involves prompting, chaining, and role-playing (Nash, Thorpe, & Andrews, 1979). Prompting is used to elicit a response from the child when none is given. The therapist may model the correct or appropriate response first and include the use of prompts, either verbal or physical. Then a request is made. The child is prompted to respond and rewarded each time a response or successive approximation of the response occurs. Once the child successfully performs, a combination of responses is tried. This combination of desired responses is also referred to as “chaining”. When the child becomes more comfortable and able to speak, role-playing may be added to generalize speech to others and a variety of
settings. Perhaps, a second adult becoming part of the therapy and role-playing may allow the child to practice speech first before transferring speech to another adult.

The multimodal approach to therapy involves the use of varying types of treatment which can be behavioral or cognitive behavioral therapy, psychoanalysis, pharmacotherapy, and play/family systems therapy to name a few. Moldan (2005) used a multimodal approach to treatment as described previously. One important element to Moldan’s approach was the inclusion of social skills training, which may be critical in the effort to increase the child’s social functioning, especially among peers. Wright et al. (1995) also used a multimodal approach with the pharmacological incorporation of SSRIs such as Fluoxetine to treat the underlying anxiety, which is the basis of SM. This kind of pharmacological intervention with behavioral therapy is critical to future interventions and treatment of children with SM, and one that must be explored with medical and clinical practitioners. The anxiety must be decreased to increase speech in social settings. SSRIs decrease the inhibition, anxiety, social phobia, and stress the child with SM feels. In this case, the SSRI acts as an anti-anxiety rather than anti-depressant (1995).

Small group settings are best when treating the child with SM. Anyone working with the child should “avoid reinforcing the mutism” (Wright et al., 1985). Although it can be difficult not to reinforce the mutism, the best progress can be made when the child overcomes their anxiety and fear of speaking in public. It should be mentioned that the child should not be forced to talk. Parents may attempt to force speech so the child does not appear rude or inconsiderate. However, forcing can cause further anxiety towards speaking in public. The family should be involved in the intervention process via training and planning.
Proposal for Conducting Group Therapy with Children with SM and their Parents

This proposed group is designed for working in a mental health clinic setting with parents and their four-to-sex-year-old children who have a diagnosis of selective mutism. The therapist works with a psychologist and another therapist to conduct a group that works initially with parents and children separately then brings them together at the end of each session. This group is designed to provide psychoeducation and counseling support to both parents and children to: provide education on the disorder, introduce cognitive behavioral techniques to parents and children in a group setting, build social skills, provide parental support, reduce anxiety associated with the child’s speech, and generalize the child’s speech with other children and adults (Reuther, Davis, Moree, & Matson, 2011; Sharkey et al., 2008). Preparation includes a parental needs survey, obtaining parental permission, and setting group rules with children (Corey, Corey, & Corey, 2010). In conducting a needs survey, the therapist obtains information from parents whose children have been diagnosed with SM, as well as the clinic professionals who are working with the children. Parental permission letters would be sent home with each child explaining the values and goals of the group, concerns to be worked on, techniques, and skills training. Group rules and confidentiality will be explained to the children in the initial pre-meeting.

Group Goals

Parents benefit from education on SM, as well as how to best work with their child to improve symptoms and quality of life. Other issues that would be addressed are working with teachers, finding and working with a counselor/psychologist who understands SM, medication and treatment methods, continuing behavioral therapy techniques at home, and building social skills for generalization and real world application. The program would implement a solution-
based therapy approach with a focus on cognitive behavioral therapy (CBT) techniques. Because age of onset generally ranges from 3-6, behavioral techniques would be appropriate. However, CBT has been shown to be very effective when paired with pharmacotherapy. Discussing implications for use of medication with parents, based on research on the effectiveness and side effects of the medications, will also be part of the program. Through research and working with children with SM, therapists work each week with parents and children to:

- Educate parents and children on SM and how it manifests (i.e. how it makes them feel inside, why they can’t speak, nervous feelings, why talking feels scary).
- Positively reinforce speech.
- Introduce cognitive behavioral therapy techniques to parents and children and teach parents how to manage behaviors.
- Provide parents the education on CBT, model CBT skills for SM, and give parents the opportunity to practice these skills both in group and with their children with a therapist present.
- Provide relaxation techniques and imagery.
- Provide music, art, and games as a source of social skill building and therapy.
- Work with children to build speech generalization and maintenance with peers and adults.

Objectives for this group:

- Help parents and children understand the physiological and emotional responses to SM.
- Provide a supportive environment for parents and children.
- Reinforce positive behavioral changes, encouraging speech.
- Model and help children to practice social skills in group.
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The group format consists of a pre-meeting in which children come with parents to meet the other children and address group rules. The first few sessions begin with education about SM to parents and children and peer play time once the groups break off. The following 6 sessions are spent working on various techniques and activities designed around building skills, relaxation, reinforcing speech, and art/drawing/crafts and games to build social skills. During this time, therapists also work with parents on some of the psychoeducation and counseling support, as well as other goals described in the interventions. The final two sessions will focus on termination of the group and more independent practice of skills and speech.

**Parental Interventions**

In the beginning, the therapist focuses on getting members comfortable throughout the initial and transition stages, followed by psychoeducation and discussion of the disorder. During the working stage, the therapist discusses various resources such as teachers, counselors, and psychologists, as well as treatment options, with multimodal treatment (i.e. SSRIs, behavioral techniques, and psychosocial) being most advantageous for success (Cohan et al., 2006; Moldan, 2005; Wright et al., 1995). During this component, the therapist may address concerns or questions related to medication and SM. The therapist also teaches Adlerian and behavioral techniques that parents can use with their child. During role-play, parents can practice behavioral techniques that they can later use with their children both during the parent-child component and in other environments (Corey et al., 2006; Corey et al., 2010). The therapist guides parents in their use of encouragement throughout the parent/child interaction. To provide therapeutic support to parents, members are encouraged to express feelings, fears, concerns, frustrations, and personal experiences with their child. This component is important to build group alliance and mutual understanding of common experiences.
Child Interventions

Interventions best used with children are behavioral and CBT interventions such as contingency management, shaping and stimulus fading, systematic desensitization, social skills training and modeling, reinforcement, self-regulation, and relaxation training (Cohan et al., 2006; Moldan, 2005). In the beginning, the therapist allows non-verbal communication but the goal is to move toward verbal expressive communication (Sharkey et al., 2008). Some things the therapists could do with children are to help children “practice” speaking and generalizing this speech to peers. Therapists also work on social skill building by teaching social cues, helping children learn to communicate with each other through playing games, and adding more peers as the child feels comfortable (i.e. starting with leader and child, then adding another child to the group).

Therapists also teach relaxation and coping techniques through visual and imaginative imagery. For example, the therapist encourages children to create or draw an image that is calming or soothing that they could refer to when they begin to feel anxious. Therapists also ask children to close their eyes and create an imaginary calming image that they can bring up when they feel anxious. Another helpful relaxation technique is to teach children physical tightening and relaxing of muscles. For example, they can imagine they’re a cat: they’re going to begin by scrunching up their face and then relaxing, tightening up their hands and relaxing, tightening up their abdomen and relaxing, and so forth as they go through their whole body. It could also be helpful to teach breathing techniques. Finally, one other effective intervention is having the child make a picture of “Mr. Worry”. He is a worried cloud that ranges from 1 (small) to 10 (big). This way the child can visualize him and point to how big Mr. Worry is in certain settings, but she can also work at shrinking and making Mr. Worry go away.
Evaluation

In order to evaluate the effectiveness of the group, the group leaders will give the parent participants an evaluation at the termination of the group. The evaluation form appears in the Appendix. The evaluation process for the group is to understand what the group found most and least effective and valuable about their experience (Corey et al., 2010). It is also important to understand whether the group received enough support, or if there should be less emphasis on psychoeducation and more on therapeutic support. Evaluation can improve future groups and leadership as well.

Conclusion

Because SM is a rare disorder, assessment, diagnosis, and treatment can be complicated by misdiagnosis. Therefore, therapists working with both children and parents must be competent in their knowledge and therapeutic skills in dealing with SM. A parent and child group therapy intervention is helpful to get group members to progress in their work beyond individual therapy. A parent therapy and support component provides parents a place where they are more comfortable supporting each other and sharing common experiences as well as allowing them to put into practice some of the techniques they have learned. Because children have had a chance to become familiar with their peers during the group process, therapists can begin working with children on behavioral, social skills, and relaxation techniques. The study of SM not only provides sufficient knowledge regarding effective levels of assessment, diagnosis, and treatment, but also provides the appropriate information for clinicians to properly diagnose. Further research is needed in the areas of feasibility and effectiveness of group therapy for children with SM. Because children with SM lack a “voice” to speak about their differing ability, therapists provide a means to advocate for better diagnosis and treatment of SM.
Appendix

Evaluation for Parents Supporting Children with Selective Mutism: A Treatment Group

We hope you have learned more about yourself, as parents, and your children by participating in the Parents of Children with Selective Mutism group. The purpose of this group was to provide psychoeducational and counseling support for both parents and children. We are asking for your feedback and evaluation about the group process, outcomes, and leader performance. This will help us as leaders to become more effective and continue to make our group and leadership more effective! Please answer the following questions on a scale of 1 being strongly disagree and 5 being strongly agree.

1. Did you find the group versus individual format effective?
2. How would you rate the effectiveness of the group leaders?
3. Was there a good balance between education and therapeutic skills?
4. How well did the intervention and practice time fit with your expectations of the group?
5. How effective were the behavioral and social skill building exercises?
6. How did you like the group structure in terms of separate parent/child time and together time?
7. How well supported did you feel by the leaders?
8. How well supported did you feel by the group members?

Please answer the following questions:

9. Are you leaving the group feeling as though you have a better understanding not only of SM but also your child, behavioral techniques, and your role as a parent?
10. What did you feel was the most and least valuable in this group?
11. If you were to change anything, what would it be?
12. How will you use the information provided in this group in the future?

13. Did we provide enough resources for you, and if not, what more could we provide?
References


