COLLABORATION BETWEEN A SPEECH AND LANGUAGE PATHOLOGIST (SLP) AND A MARRIAGE AND FAMILY THERAPIST (MFT) IN TREATING SELECTIVE MUTISM: A CASE STUDY REPORT

Henriette W. Langdon, Ed.D., F-CCC-SLP, BCS-CL[1]
Maxine B. L. Starr, Ph.D., Licensed Marriage and Family Therapist[2]

[1]Professor Emerita San Jose State University, San Jose, California. USA
Co-Owner, Sunflower Therapies, Rancho Cucamonga, California. USA
9267 Haven Ave Suite 145 Rancho Cucamonga, CA. 91730. USA
Henriette.Langdon@sjsu.edu

[2]Co-Owner Sunflower Therapies, Rancho Cucamonga, California, USA (MFT)

Abstract

In this article, we provide an intervention plan that was implemented with the collaboration of a speech and language pathologist (SLP) and a marriage and family therapist (MFT) for an 8-year-old bilingual child who was diagnosed with Selective Mutism. A description of characteristics of children diagnosed with Selective Mutism and a review of various intervention approaches are provided.

Keywords

selective mutism, intervention for selective mutism, collaboration between SLPs and MFTs, case study

Description of Children with Selective Mutism

Six in 1000 children are estimated to be affected by the diagnosis of *Selective Mutism*, characterized by the child not speaking in certain situations, but speaking in others. This disorder is not caused by neglect or abuse and is coded in the *Diagnostic and Statistical Manual of Mental Disorders*, or *DSM-5*, as 313.23 F94.0 (APA, 2013). The disorder has been recorded to be in existence since 1897 (previously also called "aphasia voluntaria" or "elective mutism" (Zuma, 2017). There is no single cause for the disorder; the causes are multifactorial (Cohan, Price, Stein, 2006). Signs of the problem are that the child might be very talkative at home, but not at school, with friends or teachers. Many researchers document that this disorder entails an underlying psychological component such as anxiety disorders, social phobia, separation, and obsessive compulsive disorder (Beidel, Turner, 2007; Black, Uhde, 1995).

The disorder appears to be slightly more common in girls and the onset is about 5 years of age (Bergman, Piacentini, McCracken, 2002; Elizur, Perednik, 2003; Black, Uhde, 1995; Dummit et al., 1997; Steinhausen, Juzi, 1996). However, the disorder may be identified earlier as soon as the child moves more outside the home environment (2 to 3 years of age) (Viana, Biedel, Rabian, 2009). It becomes more apparent when children enter a day care center, preschool or school grade where they are expected to speak in a different environment than home. However, children who come from bilingual homes should not be diagnosed with mutism unless it is present in a second as well native language. Intervention has generally focused on the psychological aspect of the disorder, involving professionals like psychologists, psychiatrists, marriage and family therapists, social workers, or other mental professionals. Most of the literature documents that speech and therapy alone has been ineffective (Swartz, Shipon Blum, 2005). Although social workers, psychologists and counselors may be involved in the process in addition to speech and language pathologists, very few researchers mention the role of a marriage and family therapist (MFT) who is trained to work with children and their families and who would collaborate with the speech and language pathologist (SLP) as well.

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Maxine B. L. Starr, Ph.D., Licensed Marriage and Family Therapist

In this paper, we begin with a review of different approaches to treat selective mutism and the professionals who have delivered therapy. A case study is presented at the end to illustrate the collaboration between an SLP, MFT and family to demonstrate that mutism should be treated with the assistance of specialized professionals and the family.

A Review of Different Treatment Approaches for Mutism

Cohan, Chavira and Stein (2006) conducted a literature review of research between 1990 and 2005 that had reported different approaches in treating children with selective mutism who presented a variety of symptoms identified in this disorder. And, in her review of the literature, Wong (2010) discussed many comorbidities that accompany this disorder such as enuresis, encopresis, obsessive compulsive disorder, speech and language impairment, and autism. Because of the diversity of comorbidities, therapy approaches had to be very individualized and because of small samples used in research studies, generalizations might be more difficult to make. Approaches suggested were psychodynamic (play therapy), behavioral therapy (i.e., positive/negative reinforcement; token procedures; shaping and prompting). Collaboration with the family (including family and siblings) as well as the teacher is also listed including medication therapy to decrease anxiety symptoms. However, exclusive therapy using medication may not always be as effective as a combination of medications paired with behavioral and family therapy (Wright, Cuccaro, Leonhardt et al., 1995). Diliberto and Kearney (2016) proposed various approaches based on three main psychological profiles that have been identified in individuals with elective mutism: anxious, anxious-mildly oppositional, and anxious-communication delayed. In their study with 57 children whose mean age was 6.7 years, the researchers found characteristics for two main factors, anxiety, and oppositional behavior. Those children who presented the anxiety profile displayed behaviors such as preferring to be alone, fearful, being withdrawn and experiencing sudden mood changes. Those who presented the oppositional profile argued a lot, needed a lot of attention, were stubborn, sullen and had temper tantrums. The researchers suggest that professionals identify the students using specific descriptors to prescribe a given treatment approach. For example, students who fit the first profile may benefit from practice in reading aloud in the classroom and relaxation techniques along with practice in interacting with unfamiliar persons when being at home. Other approaches which they refer to as creative expression therapies through play, drama, and art might be helpful to those who are fearful of being judged, or need for self-protection. However, overall, a collaboration between school and home environments is important in any case. Johnson and Wintgens (2015) report that parental involvement in the treatment of mutism is a recent phenomenon. Specifically, the authors mention a study by Vecchio and Kearny (2009) where more favorable results were obtained in enhancing children's confidence in speaking when parents encouraged their children to participate in situations which placed increasingly demanding situations as opposed to using praise for speaking in public or reprimanding the child for not speaking when called for. Suggestions were to request parents to talk to their child about their fears, and join parent support groups. Also, the term Selective in the phrase Selective Mutism should be reconsidered. In this context, it means that the child has chosen not to speak, when in fact, children with Selective Mutism may not speak because a context may make them uncomfortable and fearsome. Therefore, Johnson and Wintgens (2015) suggest the renaming of the disorder as Situational Mutism.

A more recent approach to treating children with Selective Mutism has been the implementation of CBT, otherwise known as cognitive behavior therapy. CBT treatment is based on the premise that cognitive factors, such as one's belief system, maintain mental and psychological stress. This treatment was pioneered by Beck (1970) and Ellis (1962). A recent meta-analysis of research on its efficacy for a number of psychologically based problems such as substance abuse, depression, schizophrenia, insomnia, and eating disorders amongst others revealed positive outcomes. Hoffman et al., (2012) report specific results for the disorders listed above and many other psychologically based problems. In a more specific recent retrospective analysis conducted by Lang, Nir, Gothelf et al., (2016) for children with mutism showed that those who participated in the study and received treatment using cognitive behavioral therapy techniques had significant decreased social anxiety and phobia. The researchers based their findings from parent interviews conducted on 36 children initially diagnosed with Selective Mutism who had received CBT treatment. However, they noted that treatment needs to be conducted with the intervention of a speech and language pathologist (SLP). Shum (2002) provides several strategies that the SLP might follow to assist the student with development beyond the confines of the therapy. For example, once a student is comfortable in communicating with the psychologist or mental health professional, Shum recommends that the SLP assists in the connection between the communication demands during a one on one interaction to the classroom. For example, pair the student with one that he or she likes in the classroom to complete activities, work on development of speech by accepting communication through drawing, writing and finally through words. The scope of this paper does not allow us to elaborate on more detailed suggestions in guiding the SLP in the intervention process. Those suggestions may be found in resources such as (ASHA, n.d). After the child has improved their comfort level of being able to communicate more freely in the classroom, the treatment team should work with the child on being able to generalize their communication to outside environments, such as the grocery store, a restaurant, or calling their friend on the phone (Kotrba, 2014).

Very little research we reviewed addresses specifics on how a mental health professional who is trained in family dynamics may collaborate with an SLP in the school setting, the teacher, and the family to work with a child who has been diagnosed with Selective Mutism beyond meeting to discuss assessment results. The real question remains: After one assesses a child who may have a diagnosis of Selective Mutism, how does the treatment team effectively intervene and communicate to implement clinically appropriate treatment? Although psychologists and other health professionals have similar training in various therapy approaches, the training of MFTs has particularly emphasized and adopted the philosophy that: "a renewed public awareness of the value of family life and concern about the increased stresses

on families in a rapidly changing world" (AAMFT, 2018). According to Kotrba (2014) it is important for all treatment team members (who may very well include SLPs and MFTs) to ask each other the following questions: How has the child been progressing in the school setting? How has the child been progressing in the clinical setting? How are they making progress towards their current goals? How else can we assist the child, or what other possible interventions do we need to look at to help this child make progress on their goals? A strength- based approach is recommended to look beyond the words expressed by the child and to take the child's strengths into consideration as to how they may positively impact treatment outcomes.

The case of Pamela

Pamela, an 8-year-old Hispanic female, was referred by her second-grade teacher for an evaluation. Her refusal to speak at school resulted in being made fun of by peers, poor social relationships, and overall frustration from her teachers and SLP (she was classified under the 'voice' category to receive services). Pamela's mother, a monolingual speaker of Spanish was adamant that she would speak at home but just not at school. She stated that Pamela's refusal to speak had been occurring since she started school two years prior. Pamela was retained in first grade due to difficulties in keeping up academically. (Pamela was placed in all English-speaking classroom). She was cooperative during family sessions; but would not initiate contact with school personnel.

Although minimal progress was attained after two months of counseling, Pamela seemed to enjoy the one on one interaction with the MFT as she smiled and was willing to engage in the activities presented by the therapist. Spanish was used during those sessions. Over the initial two month period, the MFT attempted interventions such as play therapy to facilitate rapport building, comfort with dialogue, brief cognitive behavioral therapy including modeling appropriate social skills such as turn taking and verbalizing one's wants and needs; as well as providing psychoeducation about common emotions and emotional expressions, and involving Pamela's mother in office sessions where appropriate. Pamela also enjoyed the one on one interaction with the SLP who was monolingual in English, but did not interact verbally with either specialist. Furthermore, she "seemed to freeze" during speech therapy sessions with other children. Because of lack of progress, both specialists realized that a closer collaboration was necessary between the two specialists, the parent, and the teacher. The team decided to try on new techniques, which were proposed by the MFT to ease pressure from speaking such as using authentic movement, which involves being in the moment with the client and modeling and/or imitating their movements (Chodorow, 2010). The techniques utilized by the therapist increased Pamela's non-verbal responses such as nodding and some two to three-word responses in both languages.

The strategies proved to be very helpful in easing her anxiety and resulting in her beginning to speak in a whisper. Pamela still communicated with movements primarily, and responded well when the specialists brought in musical instruments such as a tambourine, and then ultimately, she did begin to respond verbally. Within two months, her ability to respond to the SLP increased as well and greater frequency of audible speech was noted. Collaboration with her teacher, the principal, her mother, and her speech and language pathologist was important to diminish the pressure they put on her to speak. Implementation of techniques such as active imagination, art therapy, authentic movement, or therapeutic silence to increase her comfort level with speaking was encouraged. Also, instrumental was a change in the environment where the therapy took place. Once the SLP and MFT succeeded in coordinating with Pamela's mother efforts to provide therapy in the home, (which was Pamela's more relaxed environment where she felt more comfortable and free to communicate), Pamela's mood both at home and at school drastically changed. Her face lit up when she saw both the SLP and the MFT whom she already knew, enter her home. She was able to point out items in her room, and explain in both English and Spanish what her favorite dolls and games were. She initiated conversations with both specialists and overall, her physical signs of anxiety that she had previously displayed (e.g., repetitive hand motions, poor eye contact) decreased as she could more effectively communicate her wants and needs. Through collaboration with the specialists as well as Pamela's parent, teacher, and school staff, as well as realizing Pamela's strengths to bridge together her home strengths alongside her school performance, she began to blossom at school, make new friends, and increase her ability to advocate for her wants and needs as she was able to increase her comfort level in the school environment.

We realize that additional research is needed to duplicate this model of utilizing collaborative, interdisciplinary treatment with a greater number of subjects, but this case serves to support the importance of collaboration between speech and language and mental health professionals as well as the family and marriage therapist in giving a voice to the child who was initially diagnosed with Selective Mutism.

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