The Importance of a Team Approach in Working Effectively with Selective Mutism: A Case Study

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The Importance of a Team Approach in Working Effectively with Selective Mutism: A Case Study

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Abstract

Selective Mutism (SM) in children and adolescents is characterized by a persistent failure to speak in certain social situations including at school or with friends despite the ability to speak and comprehend language. Not due to a specific communication disorder, SM is actually a pervasive psychological problem that lies along the continuum of anxiety disorders, and therefore, requires expertise in determining how the problem is supported and maintained by a child’s history, family, and environment (Giddan, Ross, Sechler & Becker, 1997). This article represents a case study of a selectively mute child and a successful comprehensive treatment plan that was developed by a multidisciplinary team in consultation with the child.

Keywords

selective mutism, elective mutism, multidisciplinary team, multidisciplinary approach, mental health, elementary school problem, anxiety disorder.

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SUGGESTED CITATION:

Selective Mutism (SM) occurs in children and adolescents who refuse to speak in some social situations including at school despite their ability to speak and comprehend language. Such children are often first identified in the school setting as a result of a consistent refusal to share their voice in that environment. Several of these children speak at home, although they may discriminate when it comes to sharing their voice with certain family members.

Cline and Baldwin (2004) estimate a prevalence rate of six to eight cases per 1000 children through childhood and report an age of onset usually before age five. Females are believed to be slightly more affected. Not due to a specific communication disorder, SM is actually a pervasive psychological problem that lies along the continuum of anxiety disorders. Expertise is required in determining how the problem is supported and maintained by a child’s history, family, and environment (Giddan, Ross, Sechner, & Becker, 1997).

Effective treatment of SM involves a multidisciplinary team consisting of the child, caregivers, school personnel, and mental health professionals. The team works collaboratively to develop and implement a treatment plan designed to increase the child’s production of speech across settings by creating an environment wherein the child’s anxiety is lessened. This article describes a specific case study and the positive outcome of using a multidisciplinary approach to treatment. It is presented from the perspectives of the child’s parents, the mental health professionals, two classroom teachers, and the school administrator who all worked collaboratively to develop and implement the treatment plan.

Case History

The presenting client who had a history of SM was a five year old boy. He was referred to the Anxiety Disorders Service for Children and Youth (ADSCY) at the St. Boniface General Hospital by the school Social Worker as he had never spoken in school. The family was comprised of a mother, father, and younger sibling. The child was enrolled in a K – 6 school in an urban setting with a total population of 500 students. Early development was reported to be normal, “textbook”, according to parents. In terms of communication, he was introduced to and spoke only Chinese for the first two years of his life. After that he was introduced to English. He continued to speak Chinese in the home with his mother and English in other settings.

At the time of intake he only spoke with his parents and younger sister. In the previous six months, he had stopped talking with select close relatives. Parents reported that their son developed an unusual number of fears (e.g. pumpkins, gnats, etc.) by age three. Despite not speaking, parents actively enrolled him in a variety of extra-curricular activities. He was completing Kindergarten, and although he was described to like school and liked to play with other children, he would not talk with anyone in the school. When the school’s speech and language pathologist was consulted, she expressed that this child’s reluctance to speak at school was the primary issue as opposed to any irregular speech patterns or articulation problems. Indeed, no academic or learning difficulties were reported by parents or the school. When playing with children his age he would engage in activities and give

From the beginning, a shared team culture developed wherein team members achieved consensus around the purpose.
verbal feedback such as laughing and making gestures. It is interesting to note that although he did not engage in direct verbal conversation with others, he would respond verbally to questions by answering his parents. As a result, his voice could be heard by others who were close by, although it was very quiet.

The Team

The team consisted of parents, the classroom teachers and school administrator, as well as the Social Worker and Education Coordinator (Special Education Teacher) both from the ADSCY at St. Boniface General Hospital. Following the referral, the Social Worker, who worked in the capacity of case coordinator, began meeting with the student and his family on a regular basis in order to establish rapport and build a therapeutic alliance (for progression of treatment see Table 1). The Social Worker enlisted the support of the Education Coordinator and a team meeting with parents and the school followed shortly after. Although the student never attended any of the team meetings, he was advised that a team had been formed and was working to help him share his voice at school, in the community, and with extended family members.

Regular team meetings that alternated between the school and the mental health facility were key to our team’s efforts to develop an effective treatment plan that could extend to the home, school, and community. From the beginning, a “shared team culture” developed wherein team members achieved consensus around the purpose, the division of tasks, and what we expected from each other. Communication and collaboration through regular meetings and ongoing e-mailing resulted in a clear definition of roles that paved the way to mutual cooperation and trust. A shared team culture was instrumental in that it allowed individual members to fully utilize their knowledge and skills in order to develop a comprehensive treatment plan (Farrell, Schmitt, and Heinemann, 2001). What follows here are the unique observations and viewpoints of each team member (given in their own voice) who worked collaboratively to develop and implement treatment.

Parents’ Observations

After speaking with the school Social Worker, we were introduced to the diagnosis SM and he recommended ADSCY at St. Boniface General Hospital. Our initial and brief reaction was “how could there be anything wrong with our child? Perhaps if we waited a bit more this would correct itself”. But, we thought, “what if we are wrong?” Our son was not speaking at school. The teacher already had difficulty evaluating some of his abilities. We could see, later, that his mutism could isolate him and negatively affect his attitude at school and feedback back into his mutism. Neither the school nor we had a plan for bringing out his voice. Our understanding of children was that the chances of changing any behavior were easier at a younger age. If we wanted to attempt a change it would have to be as early as possible.

Plainly, a step approach was needed, but we had no idea what the steps should be. During the initial sessions at St. Boniface Hospital, we looked for direction on how to proceed and were passive observers as the Social Worker worked with our son. It wasn’t

Several of these children speak at home, although they may discriminate when it comes to sharing their voice with certain family members.
until we discussed the strategy of “reward”, that we understood the approach we needed to take. It also underscored another incentive for early intervention: desirable rewards for a five year old are less expensive than rewards for an older child. The light, playful approach that was utilized seemed well suited to our son, if not for any child. We believe this created an atmosphere such that he never resisted and even enjoyed the frequent sessions with the Social Worker.

Table 1: Progression of Treatment

<table>
<thead>
<tr>
<th>Child selectively mute during Kindergarten</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher consultation with Speech and Language Pathologist</td>
</tr>
<tr>
<td>- not identified as a speech/language problem</td>
</tr>
<tr>
<td>Referral to School Social Worker</td>
</tr>
<tr>
<td>Referral to Anxiety Disorders Service for Children &amp; Youth</td>
</tr>
<tr>
<td>- initial intake</td>
</tr>
<tr>
<td>- consultation with service Social Worker and Education Coordinator</td>
</tr>
<tr>
<td>Formation of Team</td>
</tr>
<tr>
<td>- team goals and roles defined</td>
</tr>
<tr>
<td>- implementation of Video Feedback Treatment</td>
</tr>
<tr>
<td>Development and Implementation of Comprehensive Treatment Plan</td>
</tr>
<tr>
<td>Social Worker</td>
</tr>
<tr>
<td>- ongoing meetings with parents and child</td>
</tr>
<tr>
<td>- established therapeutic alliance</td>
</tr>
<tr>
<td>- developed progression of vocalizations with child</td>
</tr>
<tr>
<td>Education Coordinator</td>
</tr>
<tr>
<td>- shared information about SM</td>
</tr>
<tr>
<td>- conducted informal interviews to explore current pattern of communication and social connections</td>
</tr>
<tr>
<td>Parents</td>
</tr>
<tr>
<td>- established reward system</td>
</tr>
<tr>
<td>- planned peer connections</td>
</tr>
<tr>
<td>Teachers</td>
</tr>
<tr>
<td>- provided peer education about SM</td>
</tr>
<tr>
<td>- met individually with child twice a week to promote progression of vocalization</td>
</tr>
<tr>
<td>- implemented step plan to help child generalize his voice to peers and increase voice volume</td>
</tr>
<tr>
<td>School Administrator</td>
</tr>
<tr>
<td>- provided release time to teachers to develop treatment plan</td>
</tr>
<tr>
<td>- coordinated schedule of staff to facilitate teacher one-on-one time with student</td>
</tr>
<tr>
<td>- acquired materials for professional library</td>
</tr>
<tr>
<td>Child shares full voice in school and beyond</td>
</tr>
</tbody>
</table>

After a little more than one year he was comfortable with using a book or toy to “break the ice”. Using this strategy he began sharing with more and more people. As his sharing progressed we occasionally encouraged (but did not force) him to do without the “ice breaker”. Eventually, as his confidence grew, he did drop the “icebreaker”. Little
more than two years from when intervention started he told us he no longer needed an “ice breaker” and began responding to people without coaxing.

There is plenty of praise when he shares his voice and he still beams each time. We still provide little rewards for sharing his voice and larger rewards for cumulative sharing, but it is a very small price to pay.

Case Coordinator’s Observations (Social Worker)

After the initial intake was completed at St. Boniface General Hospital, the Multi-disciplinary Team of ADSCY decided that a family systems approach was indicated. The nature of SM and the age of the child were factors which supported the decision to involve all family members. The intervention process could be conceptualized into several areas: beginning steps, focus on speech, and generalization to other settings.

The initial goal was to build connections with the family, in order to build trust and strengthen the concept of the parents being part of the team. A second goal was to discuss with parents their role in encouraging their child to face his fears by using rewards. According to Rapee, Spence, Cobham, and Wignall (2000) and Chansky (2004), rewards are an effective tool to increase the child’s willingness to battle fears. “Another advantage of rewards is that they change the tone of the work from serious and fearful to something positive” (Chansky, p. 98). Connecting with the school system was also an important element, as they were conceptualized as part of the treatment team. The framework and goals of the intervention, as well as education about SM, were also part of the initial focus.

Early on in the intervention, the focus on speech and the goal of helping the child to share his voice was established. All components of the “focus on speech” involved several similarities. There was a strong play component, in order to engage the child in the activity. This helped to lighten the child’s mood and encourage laughter and playfulness. The use of humor was an integral piece of the work of therapy. It helped to provide an opportunity for vocalization and to lighten the atmosphere of the therapy sessions. In the Journal of Mental Health, Dunklebau (as cited in John, 1999) reported “...humor used consciously (rather than intuitively) can be very effective both in building a relationship with a client and in furthering a therapeutic intervention” (p.540).

A significant part of the strategy to work towards the goal of sharing his voice involved breaking down the components involved in early communication (see Table 2). For example, actual words or sentences were not the initial focus, but rather gestures and non-descript noises such as clicking with the tongue.

Table 2: Clinician Directed Progression of Vocalizations

<table>
<thead>
<tr>
<th>Progression</th>
<th>Vocalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestures</td>
<td>(e.g. wave goodbye)</td>
</tr>
<tr>
<td>Non-descript noises</td>
<td>(e.g. clicking tongue to say goodbye)</td>
</tr>
<tr>
<td>Sounds</td>
<td>(e.g. car noises, animal noises)</td>
</tr>
<tr>
<td>Word Sounds</td>
<td>(Progression: giving first sound of word; last sound of word; saying sounds of all letters in word; stringing together several sounds; putting word together)</td>
</tr>
</tbody>
</table>
It is important to note that the sequence of increasing vocalizations was consistently used with the child in both the clinic by the Social Worker and in the school by the teachers.

Sharing of the voice by the child first occurred with myself. Although successful vocalization within the clinical setting was one of the treatment goals, the real focus was on generalization to other settings (e.g. school, conversation with extended family). Ongoing consultation and coordination with the team (i.e. parents, school, clinic) was an important piece that helped generalize the child’s vocalizations to other settings.

Education Coordinator’s Observations

My initial involvement with this case began by providing information to the team about SM in terms of diagnostic criteria, effects on children’s learning, and general guidelines for intervention. It was especially important to emphasize the role of anxiety in the child’s decision not to share his voice, and the need to develop a treatment plan slowly and carefully, in order to avoid reinforcing a long established pattern of behaviour (Cline and Baldwin, p. 79). Time was also spent discussing the behaviours which serve to maintain and reinforce mutism at school, such as when adults resort to rhetorical or yes/no questions in their interactions with the selectively mute child, or when other peers begin speaking for the child. As a team, we discussed the importance of establishing an agreed upon expectation for this child to share his voice, and talked about some of the consequences that would result if he did not choose to speak in a variety of settings.

An informal interview was conducted with the team to determine the child’s current pattern of communication and social connections both at home and at school. Team members were asked to consider whether any learning needs were apparent, what strategies had already been used with success, and what reinforcers appeared effective. In consultation with the Case Coordinator and Mental Health Team, we decided to pursue the Video Feedback Treatment (amended version of the Audio Feedback Treatment) described in Cline and Baldwin (2004). Using self-modeling, the parent videotaped the teacher asking a series of questions previously compiled by the team. The parent asked the child the same questions and videotaped his responses. The two tapes were edited together to produce a fake video where the child appeared to be answering his teacher’s questions. The video was shown to the child twice a day over the course of several weeks in order to foster the child’s perception of his own competence. This proved effective in engaging the entire team around a common goal and served as a springboard to motivate the child to begin working toward sharing his voice with others. Ongoing team meetings and regular communication among team members afforded us the opportunity to discuss the “next step” and thereby devise and coordinate a specific treatment plan. Various step plans or hierarchies, reinforcement schedules, and time frames were all developed in consultation with the child. The intervention was flexible in that the child was allowed to make decisions in regards to who he preferred to sit next to in class, what object he would bring to share with his teacher during

Little more than two years from when intervention started he told us he no longer needed an “ice breaker.”
Show ‘n Tell, and whom he chose to speak to next on his hierarchy.

School Administrator’s Observations

An important factor in this success story was the structure which was established to support the child and the team. This particular school is part of a learning community that embraces a common purpose: we are dedicated to educational excellence through challenging and enriching experiences for all, in a safe and caring community. In order to achieve this purpose, some programming must be custom designed to meet the needs of children that learn differently and require special environmental supports. In keeping with our vision, the staff believed that they could make a difference in this child’s life.

In addition to regular team meetings and ongoing consultation, we also provided release time to the classroom teachers to attend half-day meetings at the hospital, for workshops and for celebrations in support of the child. As we addressed the challenge of working with SM for the first time, we were able to acquire materials for our professional library. Other school personnel assisted with the implementation strategy by covering for the classroom teachers, allowing them the necessary time to meet with the student one-on-one. The classroom teachers would also use some of their prep time to meet with the child outside of the classroom, in order to foster sharing his voice in a safe and secure setting. In the end, restructurings our resources and buying two to three days worth of substitute teacher time each year, over two years, resulted in a child feeling more comfortable speaking with classmates and staff. This investment afforded us the pleasure of being part of a truly life altering success story!

Classroom Teachers’ Observations

Imagine standing in front of a classroom of students and realizing that one child has not spoken a word all week, not even to ask to go the washroom, or for clarifications about assignments. In fact, he has not spoken to any other child in the class. From the start, classroom peers were made aware that although this child did not speak, he indeed had a voice and was currently choosing not to share it.

From the beginning, the student communicated through his expressive eyes and at times laughed out loud at humorous classroom situations. Although he did not know it, this was the first step at letting others hear his voice. Humour was a great way to remove the pressure and break down the barriers between the classroom teachers and the student. Early in Grade One, this child was able to participate with the class as they chanted silly sound effects for punctuation marks in a secret message written on the board. Humour was used to pull the child even further from his comfort zone into new territory. As he slowly began speaking, humour and silly behaviour was used to cajole him to go beyond his level of comfort (e.g. increasing volume). Attempts by other adults in the school to get the student to talk, or ‘to catch him talking’, were anticipated and discouraged, in accord with the treatment plan.

This child’s comfort level was an important consideration. Early in the school year, his classroom teacher told him that he may never speak to her this year and that would be okay. By removing the pressure of
speaking early in the year, the child became more relaxed. The likelihood of teacher controlled timelines was quickly pushed aside. The student, however, was able to demonstrate his learning in other ways for the moment (e.g. writing, drawing, and home tape recordings of reading). Speech came in small doses as the child’s comfort level increased. At first, his speech was often controlled speech, using word flashcards and short reading passages. This removed pressure for the student because ‘the what’ to say was already defined. Later in the year, as per the treatment plan, teacher expectation gradually increased and resulted in the student asking to use the washroom, generalizing his voice to a small group of peers, and writing a text based on his own ideas. Throughout the intervention, classroom peers were coached by the teacher to respond “matter of factly” to any attempts by the student to share his voice. Although it caused some initial excitement among his peers, students quickly accepted hearing his voice and often complimented him on the content of his answers as opposed to sharing his voice.

Controlling the pace of sharing his voice was also an important aspect of the treatment plan. The classroom teachers guided the student in setting goals and choosing “the who” and “the when” of sharing his voice (step plan). The child identified a list of students and teachers with whom he wanted to share his voice using class lists and photographs. One teacher created a simple slide thermometer to give the student feedback about his voice volume and help him increase it as he began sharing his voice. Teachers pushed when necessary, but ultimately it was the child who felt a sense of control in the entire process. This likely served to increase his comfort level and lessen his anxiety.

Two years later, in June by the end of Grade Two, this child now stands in front of the class sharing his book about Canada. He speaks clearly, though a little softly, while telling the students about his favourite pages. Daily, he speaks to the teacher and all the other students in the class. During this school year, he has also shared his voice with all the other adults in the building that work with him. He continues to broaden his audience of students and adults. Now his smile is radiant with the pride of his accomplishments.

Humor was used to pull the child even further from his comfort zone.

Current Status

Today, the child has already completed Grade 3. His parents have gradually phased out the use of rewards to encourage speaking and have now shifted to more general rewards to reinforce academic and extracurricular achievements and good behaviour. On a recent trip overseas (December 2006) their son was observed speaking to peers, older relations, and other adults with whom he had little or no prior contact. Although he will not actively seek to initiate conversation with others unless there appears to be a shared interest, he will in most cases respond if others initiate conversation. To date (May 2007), the child has shown no signs of regressing. Parents have lost count of the number of peers and adults with whom he speaks. Now there are perhaps only a handful of others with whom he might not speak. It is a vast difference compared to the handful of people he would speak to only four years earlier. As for the child, he has forgotten much of what was done to help him share his voice. He did share that he would probably speak to almost anyone, although there may be some he
would choose not to speak to and that is fair enough.

Conclusion

Effective treatment of SM in this case involved a multidisciplinary team approach that sought to increase the child’s production of speech across settings by creating an environment wherein the child’s anxiety was lessened. From the outset, the child was made aware of the team and its work to develop a treatment plan to help him share his voice with others. The team steered clear of the use of any deception and instead worked diligently to establish open and clear communication with the child. Individualized “step plans” (or hierarchies), reinforcement schedules, and time frames were all developed in consultation with the child. The approach was guided by empirical research and patience was exercised at every turn in order to avoid overwhelming the child or coercing him to speak. A family systems approach was utilized to determine how the problem was supported and maintained across multiple settings, and interventions were developed to facilitate the gradual production of speech in those settings. Different team members used their creativity in the development and implementation of these interventions. Flaherty, Garison, Ellen, and Waxman (1998) report that creativity can contribute to a dynamic group process that maximizes service delivery while minimizing duplication of services.

A team structure that reflected flexible collaboration was instrumental to the positive outcome achieved here. A team consisting of the child, caregivers, school personnel, and mental health professionals was very effective in treatment. Regular team meetings and ongoing communication led to the development of a comprehensive treatment plan that allowed the child to share his voice across multiple settings. We believe that the treatment plan developed here encouraged the child to attribute success to his own efforts and increased his personal sense of competency. The benefits of providing an early intervention for children who present with Selective Mutism cannot be overstated.

The
References


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