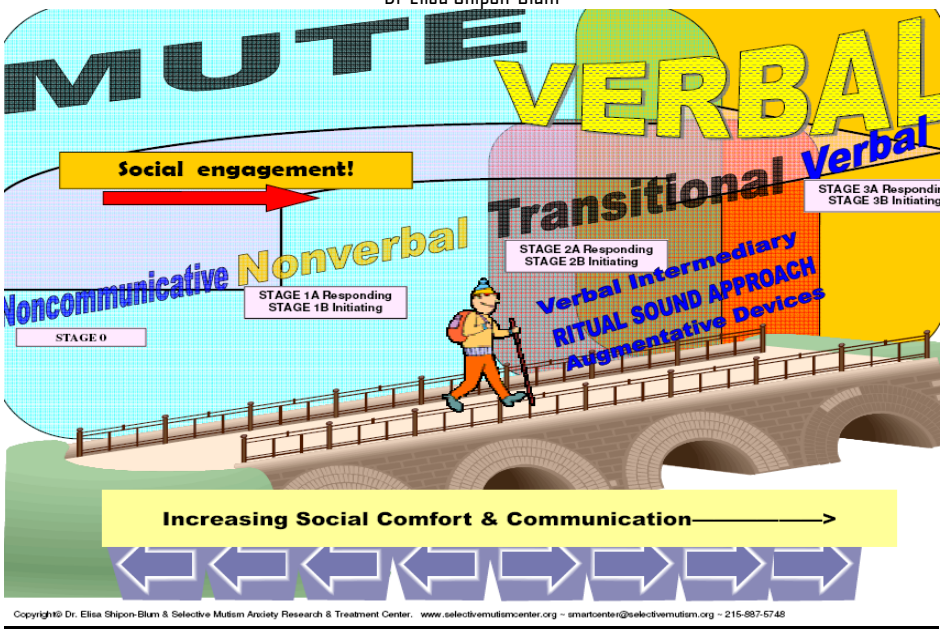
TRANSITIONAL STAGE OF COMMUNICATION © (Stage 2 of SM-SCCS)

The MISSING LINK!

Social Communication Anxiety Therapy (SCAT) ©

Dr Elisa Shipon-Blum



SOCIAL COMMUNICATION BRIDGE ©

Visual interpretation of the SM-SCCS Based on the SM-SCCS

Children with SM present in a variety of different ways. Some children can be shut down and noncommunicative (stage 0) while others can become comfortable but use nonverbal means of communicating, such as pointing, gesturing or nodding, etc. Some children can whisper or speak quietly to select others while remaining mute with these same individuals in a different social setting!

Therefore, NO two children with Selective Mutism are the same in terms of their social communication skills. Truthfully, for typical child with SM, if strategies and interventions are not done, yet the child feels that everyone wants him to speak, anxiety is reinforced. and he will remain 'stuck' in nonverbal communication.

Q: If a child is comfortable, shouldn't he simply start to speak?

A: IF this was the case, then I believe SM would not be considered a disorder, but merely a mild problem that only few suffer from. The reality is that comfort alone is often not enough to prompt speech. In fact, research at the Smart Center indicates that unless strategies/interventions are in place, the child often remains nonverbal or progress can be quiet limited esp. if the child feels people ware wanting him to speak!

Q: For the nonverbal child, is lowering anxiety enough to stimulate speech?
A: For the majority, the answer is NO, especially as a child ages. For the child who is able to respond via nodding, gesturing, pointing, writing, etc. he/she may actually appear comfortable, relaxed and engaged, yet mutism persists.

Q: If anxiety is low, and the child appears comfortable, WHY does he/she just not talk?
A: MUTE behavior becomes learned, ingrained and conditioned to the point of impossibility. And with emphasis on trying to get the child to speak, such as asking him/her when and why she does not speak, reinforced mute behavior persists.

The child with SM is often STUCK in the NONVERBAL stage (Stage 1 of SM-SCCS) and cannot just BEGIN speaking. For older children/teens who have been mute for years, they are that much more STUCK, even if they appear comfortable and relaxed.

So often we hear, *'He is right there! I just know it! He will start to speak any day!'*
Sadly, this rarely happens within an environment where the child HAS been mute for a long time. *There are rare cases, specifically children with speech phobia, who are verbal in ALL or most settings but MUTE in ONE or a select few locations. I.e., the child who is MUTE in school but OUT of school he/she can speak to a teacher and/or peer(s). OR, a child who is MUTE in school but verbal in MOST other social settings. The speech phobia is specific to school. If that child is in a new setting, with those who 'do not know'

The saying; *'So close, but yet so far'* is more appropriate for the majority of older children and teens, especially those who have been mute for many years in one specific location (such as school) and with specific people (such as select relatives/friends).

Q: HOW then do you get a child to speak if lowering anxiety is not enough?
A: By helping the child unlearn their conditioned mute behavior and using

TRANSITIONAL strategies to BRIDGE from nonverbal to verbal communication.

It is this stage of communication that is the MISSING LINK in MOST treatment plans.

Treatment that focuses solely on *lowering anxiety* without regard to structured ways for parents and CHILD to UNLEARN conditioned behaviors. For the mute child, if focus is on in-office therapy without implementation of strategies outside the office treatment resistance will often occur

Q: Are there specific transitional strategies?
A: YES! There are 1000's! However, they fall under the following three headings:

(1) Verbal intermediary

-The child with SM uses a person (parent, sibling, friend, etc) or object (finger puppet, action figure, hand, etc) as a vehicle to transfer speech. Since the child has 'nonverbal skills' the child can RESPOND to his/her verbal intermediary (VI) by whispering in the VI's ear or 'telling' the person in front of another person. The child's unique characteristics will dictate how incremental the child will be towards the verbal intermediary. Some children will 'TELL' the person/object in front of another person while other children may need to 'measure' the distance and whisper to their VI 'close up'→'Fist length away'…etc. There are some children who may need to start OUT of the room, using an adjunct to begin, such as a tape recorder, etc. There are many different measuring means and methods of using a verbal intermediary. The POINT is, the child has a controlled way of transitioning.

(2) Ritual Sound Approach

- The child enters speech via the backdoor approach! A cognitive approach is used to help the child THINK of sounds from a mechanical standpoint. For the majority of children, sounds are shaped into words via a ritualistic and controlled manner where the child knows what is done, how it is done, where it is done and with whom. For more mild children, simple words can be used as a first step in transiting speech. Charts are developed under the guidance of a treatment professional but the child CHOOSES the sounds of choice, how the sounds are made, which order the sounds are made, with who the child will do the sounds, where the sounds are made and WHAT questions are asked! We use the child's feelings chart to help guide the process. Some children need to start via nonverbal means of tapping as a representation of YES (two taps are yes and one tap is no), using pre-taped messages or words on a recorder.

Other children can start with making simple mouth sounds and breathing sounds. Focusing on the alphabet and sounds of the alphabet is a logical first step for many children. The child can then CHECK off the sounds he/she made. Common beginning sounds are: H (deep break in/out), S (Pushing air thru the teeth..) and W (blowing a feather). The child is 100% aware of this process. Detailed charts are set up and the child works on his/her charts at school and possibly with select individuals at home.

(3) <u>Augmentative Devices, such as tape recorders</u>.

- For some children, they are FINE with others hearing this voice. Other children are terrified and/or simply resist. DO NOT push a child into taping his voice and NEVER trick a child and then play the tape. For those who are comfortable with taping their voice or simple sounds, we can use the recorder or other augmentative device as a step into the transitional stage of communication. The tape recorder is ideal for the child who is not comfortable with making sounds in front of another person, but willing to have others hear his/her voice. Taping common words such as YES or NO or perhaps answers to simple questions are common ways to use the tape recorder. Other augmentative devices, such as blowers, voice changers, whistles, etc can be used to help the child begin to respond or initiate via SOUND. ** We often recommend tape recorders as an accommodation (taping academics where the child can play in front of the teacher/select peers or to provide to the teacher for assessment).**

There is NO one size fits all way to transition into speech. Most children/teens use a combination of the above methods to transition across the BRIDGE© into speech.

Strategies for the REAL WORLD and with strangers are often different than strategies used with people the child KNOWS and is used to not speaking to.

<u>Each child has a unique recipe.</u> Although many 'recipes' may start out with similar ingredients, the way the ingredients are used will dictate the end result or success to treatment!

Dr. Elisa Shipon-Blum is President and Director of the SMart Center. She is also founder of the SMG (www.selectivemutism.org) as well as Director of the Selective Mutism Research Institute (SMRI).

www.selectivemutismcenter.org
215-887-5748
smartcenter@selectivemutismcenter.org
505 North Old York Road ~ Lower Level
Jenkintown, PA 19046