

Medications as Part of a Selective Mutism Treatment Plan: Fears and Facts

Few topics on selective mutism (SM) listservs bring as much passion as the issue of when to include medication as part of a treatment plan. A few disclosures so you know my biases: I could not prescribe even if I wanted to, as I am a psychologist, not a psychiatrist. I receive no payments from pharmaceutical companies and no payments for anything related to medications. I have a vested interest in advancing psychological therapies to treat SM as I am a Board Certified Psychologist. The SMA believes [research](#) should guide how parents make choices about treatment plans and that parents should have informed consent to make choices without judgement or criticism.

Don't kids want to get better? Isn't medication just the easy way out for the adults?

Of course kids want to overcome SM! I have never met a child who was philosophically committed to leading a selectively mute lifestyle. However, after months of participating in therapy with no or slow progress kids can become demoralized and lack *self-efficacy* – they don't believe they can do the behaviors necessary to overcome SM. The goals simply feel too imposing, despite the parents' excellent work breaking them down into small steps and using incentive systems. Medication is *not* the easy way out – it can be the thing that allows the child to actually participate in and benefit from the behavioral therapy. In other words, medication is not an alternative to therapy work but rather can be one part of an overall therapy program.

When should parents consider adding medicine to a treatment plan?

When families have been leading an “exposure lifestyle,” by trying hard to put into action a good behavioral treatment plan for a few months or more, and their kids are still struggling just to do their assigned exposure tasks, or they are attempting the tasks often enough, but progress is still excruciatingly slow, it's appropriate to think about adding medicine to the treatment plan. Additional factors that should lead families to consider adding medicine are when your child has one or more other highly impairing conditions interfering with healthy functioning, being on the older side (> 9 years old), and prior unsuccessful psychosocial treatment attempts. Basically, it shouldn't have to be so hard to overcome SM. No one is looking for an easy way out – just trying to avoid it being impossible and taking longer than it should. Every day that a child with SM has SM, the strength of their habit increases. To quote Dr. Marty Franklin, a famous, well-respected child anxiety expert, “We can't give you back your time.”

What’s the proof that medicine will help? What’s the proof that medicine isn’t dangerous or bad for the brain?

If you go to Google Scholar, a free resource open to parents and treating professionals alike, and search, for example, “[CAMS](#)” or “[CAMELS](#)” (the largest and longest child anxiety trials) plus “child anxiety” you will see that there is good research evidence for the combined use of cognitive behavioral therapies (CBT) and psychopharmacology *when both are done well*. You will see that combined treatments lead to generally better outcomes than either CBT or medication alone on the order of 80% improvement compared to 50-60% improvements. Space here doesn’t allow a longer discussion but you can use Google Scholar to become good consumers of the relevant research, increasing your knowledge of what research actually supports. Reviewing the research also shows that there are no documented long-term negative outcomes from taking the common anti-anxiety medicines – the SSRIs. The FDA’s “black box warning” had to do with suicidal *thinking* in depressed patients not suicidal *behavior*, and not in anxious patients. As parents, we urge you to consider potential negative effects of using medication as well as the potential negative effects on the developing brain of bathing in anxiety as much as the brain does when a child is living day in, day out with SM. Children who are untreated or under-treated are still impaired and still suffering.

If we start medicine, how long will our child need to be on it?

Allow me to paraphrase the smartest answer I ever heard in this regard, giving credit to its author, UCLA child psychiatrist Dr. Jim McCracken: When the child has reached a therapeutic dose – that is the dose at which they are achieving their interaction goals – we like to get them through one year’s life cycle of events – one successful start of school, the end of school, their birthday, holidays with relatives, a ballet/music recital, etc., before beginning the weaning process. Most people who follow this advice will tell you that weaning is successful, but that you may restart medication in the future during especially difficult developmental challenges, e.g., starting high school or college.

Which medicine is used? How do these medicines work? What’s the right dose?

The choice of a specific medicine is a very important one and is always individualized to your child in consultation with a prescribing practitioner. Typically, but not always, the first suggested medication for SM with or without social anxiety disorder will be an SSRI – a *selective serotonin reuptake inhibitor* – such as Fluoxetine (Prozac) or Sertraline (Zoloft). While the exact mechanisms for how SSRIs work aren’t yet fully understood, in essence SSRIs work by normalizing the brain’s reuptake of the neurotransmitter serotonin, which is thought to reduce anxiety. As for what this feels like to a patient, the best explanation I have heard comes from Jonathan Kohlmeier, a young adult who overcame SM through hard work in therapy and use of medication at times: “Imagine a 6-foot high wall that you very much wanted to climb over but it was simply physically impossible. What if someone could lower that wall to about 4-feet where it would still take you lots of effort but at least it is now physically possible. That’s what medicine did for me – lowered the wall so with effort I could at least get over it.”

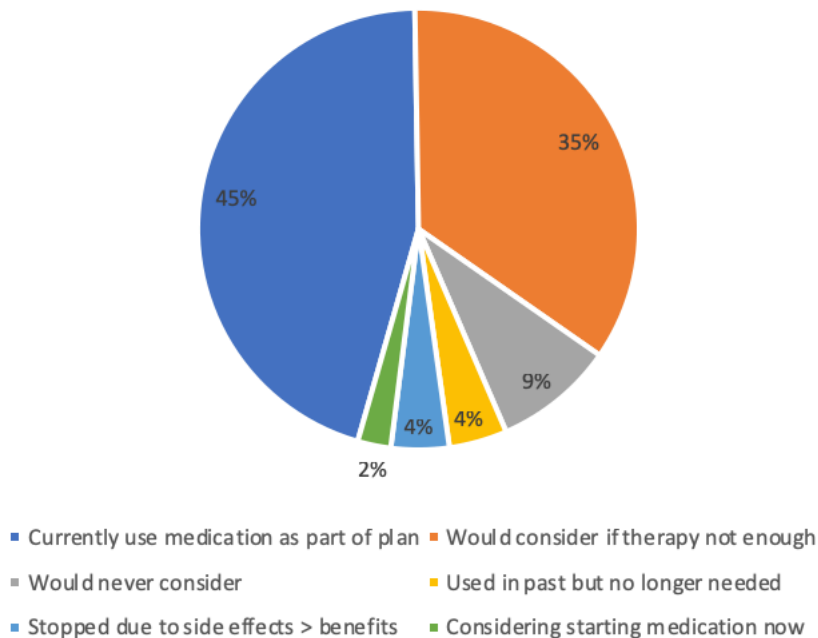
Some cautions: Be careful to avoid comparing doses with others because the therapeutic range can vary so very much. One child may get the desired effects from an 8mg dose of Fluoxetine and another child the same size may require 40mg or more. Also, be careful to avoid comparing one medicine to another – the range of Fluoxetine dosing is on the order of 10-40mg for the vast

majority of patients but Sertraline is scaled differently and effective doses are on the order of 50-200mg for most patients. Liquid dosing numbers are also different than their pill equivalents. In general, you should direct any questions or concerns about the particulars of the medication to the prescribing doctor.

How commonly is medication included in SM treatment plans?

There are no formal, well-controlled data to answer this question. A recent *informal* poll of the largest Facebook parent support group for SM revealed the following from the 329 respondents: 45% “currently use medication as part of their treatment plan,” 35% would “consider medication if their child did not adequately respond to therapy,” 4% “used medication but weaned off it due to their child doing well enough, long enough,” 4% “discontinued medication due to the negative effects outweighing the positive effects,” 2% are “considering medication” now, and 9% would “never ever consider use of prescription medication even if they have been participating in therapy and not improving adequately.” Facebook participants and people who respond to polls are not necessarily a random sample of all families living with SM but clearly a very high percentage (91%) of these respondents agree with using or considering medication when therapy alone is not sufficient.

Medications in SM Treatment Plan Poll Results



Any other tips and bits of advice in considering prescription medications as part of an SM treatment plan? What would our next steps be if we are considering medication?

Here are some other quick tips: Be weary of any nutraceuticals or other medicine-sounding alternatives, e.g., CBD oil, until and unless they have been tested for safety and effectiveness through research. Over-the-counter does not automatically equal safe or effective. If and when you are ready to consider medication, have a consultation appointment with a professional who can prescribe. This would typically be a child/adolescent psychiatrist, developmental behavioral pediatrician, pediatric neurologist, or psychiatric nurse practitioner (NP). Some, but not all pediatricians are comfortable doing a medication trial. Common physician degrees are either MD, DO, or ND.

The decision to add medicine to a child's SM treatment plan is obviously a very personal one and one that all parents take seriously. Please consult with your treating clinician and someone with expertise in medication if you have questions and to explore your options.

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