Parent–Child Interaction Therapy for Children with Selective Mutism (PCIT-SM)

Allison Cotter, Mitchell Todd, and Elizabeth Brestan-Knight

Abstract
Selective mutism is a psychological disorder in which children do not speak to others in certain social settings (e.g., school, daycare) even though they are able to speak in other settings, such as at home with family. Treatment options are often limited for children with this disorder due to the young age of onset, low prevalence rate, and type of problematic behavior displayed by the child (e.g., non-disruptive, lack of speech to clinicians). Parent–child interaction therapy (PCIT) has been adapted to fill this gap and to provide appropriate treatment for children with selective mutism. The current chapter includes a description of the clinical presentation of selective mutism as well as the etiology and maintenance of this disorder. Following a discussion of the need for a lateral extension of the original protocol for this population, the chapter describes the adapted PCIT model, including the altered assessment procedures and treatment phases. Information is also provided about medication use for selective mutism. Finally, future areas for research and clinical development regarding the adapted treatment model are discussed.

Sarah’s mother was baffled when she received news from the daycare worker that her daughter had not spoken to anyone in the center since her arrival. It was difficult to imagine how her goofy and chatty girl at home became stone-faced and reserved in daycare. Even though Sarah had always been a bit slow-to-warm-up when introduced to new people, she was open and expressive with her parents and siblings at home. Having experienced her own anxiety, Sarah’s mother could understand her daughter’s hesitation in new social situations. Still, she hoped that this behavior would change as Sarah grew more accustomed to the new setting and that her daughter would eventually “outgrow” her shyness. Unfortunately, Sarah’s silence persisted despite attempts and accommodations made by staff at the center, continuing even as she began Kindergarten. Feeling frustrated and powerless to help her daughter speak at school, Sarah’s mother was referred by the teacher to a local psychology clinic. Following a comprehensive evaluation, Sarah was diagnosed with selective mutism (SM)
and recommended for treatment services to address her lack of speech.

The Need for a Parent–Child Intervention to Treat SM

SM is a psychological disorder in which children do not speak to others in certain social settings (e.g., school or daycare) even though they are able to speak in other settings, such as at home with family. It was originally known as “voluntary aphasia” or “ejective mutism” based on the false assumption that defiance or choice motivated the child’s refusal to speak in the required social situations (Kussmaul, 1887; Muris & Ollendick, 2015; Tramer, 1934). However, more recent conceptualizations have recognized the lack of motive or agency among children with SM, rebranding the disorder as “selective” and recategorizing it under the anxiety disorders in the recently released fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychological Association [APA], 2013). Although estimated prevalence rates of less than 1% suggest the rarity of SM (e.g., Bergman, Fiorentini, & McCracken, 2002; Viana, Beidel, & Rabian, 2009), this disorder has the potential to cause great impairment in academic achievement, social relations, and mental health functioning (Busse & Downey, 2011; Muris & Ollendick, 2015; Steinhausen, Wachtler, Laimböck, & Metzke, 2006). Moreover, without appropriate knowledge of the disorder, parents and teachers often feel helpless in the face of a child’s refusal to speak and may unintentionally reinforce these behaviors, which can exacerbate and maintain the lack of speech. As such, treatment for SM is vital to restore the child’s communicative abilities and to break the maintaining cycle of avoidance.

In response to this need, parent–child interaction therapy (PCIT) was adapted to treat children with SM (Carpenter, Puiiaficio, Kurtz, Pincus, & Comer, 2014; Kurtz, 2015). This adapted version of PCIT for selectively mute children (PCIT-SM) utilizes behavioral techniques in exposure situations to decrease avoidance and to promote the child’s speech, beginning in the clinic and expanding to other social settings. Although PCIT-SM has yet to be empirically tested using randomized and controlled methods, it has shown initial success for increasing children’s verbal responses, such as spontaneous speech (Mele & Kurtz, 2013). This chapter will begin by describing the clinical presentation of SM as well as the etiology and maintenance of the disorder. Following a justification for the lateral extension of PCIT into this population, we will describe PCIT-SM, including the adapted assessment procedures and treatment phases. Finally, future areas for research and clinical development will be discussed.

Clinical Presentation of Selective Mutism

Diagnostic Criteria

The DSM-5 diagnostic criteria for SM include a “consistent failure to speak in specific social situations... despite speaking in other situations,” with the lack of speech not attributable to knowledge or comfort with spoken language (APA, 2013). Although children with SM often speak to close family members (e.g., parents, siblings) at home, they do not initiate or reciprocate speech with others (e.g., teachers, classmates, extended family members, strangers) in public settings, such as school or a restaurant. Given that it is normative and developmentally appropriate for children to experience shyness and behavioral inhibition, such as limited speech, when facing new situations, a diagnosis of SM cannot be made during the first month of a new school year (APA, 2013). Children are likely to display increased anxiety and worry when beginning a new school year, but this behavior typically dissipates over time. Additionally, the DSM-5 specifies that the child’s behavior must interfere with educational or occupational achievement or with social communication and cannot be better explained by another disorder (e.g., communication disorder, psychotic disorder, autism spectrum disorder; APA, 2013).

Typically, parents report that children with SM interact verbally (e.g., talking, reading, singing) at home but are unable to speak to their teachers and classmates in school, relying on nonverbal communication of needs. Still, the severity of SM symptoms varies on a case-by-case basis and may include differing levels of nonverbal communication (e.g., facial expressions, gestures, nodding). Across the continuum, some children may appear “frozen” with limited body movement and facial expressions, while others may utilize nonverbal gestures to communicate needs and even make noises, such as clicking or whistling (Perednik, 2011). For example, one mother reported that her daughter made noises and appeared jittery and energetic in settings where she failed to speak as if the pressure to speak was building and “trying to burst out of her.”

Development and Course of SM

The age of onset for SM is most commonly between 2 and 5 years; however, symptoms are often not apparent until children enter the school setting. As such, referral for services and subsequent diagnosis of SM tends to occur later, creating a gap between onset and treatment (APA, 2013; Viana et al., 2009). Although not consistently found, some research suggests that SM is more prevalent in females than males (Leonard & Dow, 1995; Standart & Le Couteur, 2003). Relatively little is known about the persistence and developmental outcomes of SM without treatment. One long-term study suggests that the symptoms of SM either “disappear quite suddenly” in adolescence or slowly improve over time (Steinhausen et al., 2006). Reported complete remission rates for the diagnosis range from 39% to 100%, with more recent, controlled findings of 58% remission in SM children by age 22 (Renshmidt, Poller, Herpetz-Dahlmann, Hennighausen, & Gutekunst, 2001; Steinhausen et al., 2006). However, individuals with prior history of SM may suffer from higher rates of psychiatric disorders, even into adulthood, as well as social and academic difficulties (Renshmidt et al., 2001; Steinhausen et al., 2006).

Comorbidity

Children with SM may exhibit additional internalizing and externalizing problems. High rates of comorbidity have been shown between SM and other anxiety disorders, including social anxiety disorder, separation anxiety disorder, and specific phobia (e.g., APA, 2013; Muris & Ollendick, 2015; Viana et al., 2009). For example, a mother of a 6-year-old girl with SM stated that her daughter exhibited anxiety in other situations, such as eating in public, walking into school, and being near insects. In addition, some children with SM have been found to display controlling, oppositional, and aggressive behaviors although this is less common and consistent (APA, 2013; Viana et al., 2009). However, these internalizing and externalizing symptoms may be difficult to distinguish among children with SM. For instance, a child with SM who refuses to sit on the mat for circle time because of an insect (i.e., specific phobia) is likely unable to articulate his or her concerns to others. As such, the teacher may be unable to figure out the true reason for the child’s behavior (i.e., a fear of bugs), inaccurately perceiving the behavior as defiance or opposition. It has also been suggested that children with SM do not exhibit defiance across all settings but, rather, mainly in situations that require speech (Viana et al., 2009).

Etiology and Maintenance of SM

Etiology

As with many psychological disorders, there are multiple factors that are believed to contribute to the development of SM, including genetic, temperamental, environmental, and neurodevelopmental factors (APA, 2013; Muris & Ollendick, 2015; Viana et al., 2009). These features predispose children to be at higher risk for developing SM. First, a family history of SM or other anxiety disorders appears to contribute to a genetic predisposition as well as possible environmental effects through behavioral modeling of anxious behaviors.
assessment

PCT-SE

The definition of PCT-SE

The PCT-SE is a tool used in the clinical setting to assess the presence of parent-child communication issues.

The PCT-SE consists of a series of questions that evaluate the child's ability to communicate with their parents. The tool is designed to help identify areas where the child may be struggling in their communication with their parents.

Why use the PCT-SE?

The PCT-SE is useful in clinical settings as it provides a standardized way to assess parent-child communication. This can help in identifying areas where the child may be struggling and can be used to guide intervention strategies.

Maintenance

The PCT-SE should be administered annually to monitor the child's progress in their communication with their parents.
**Understanding Pre-K Students:**

**ProProFact** (2013) provides compelling evidence of the impact of early childhood experiences on academic and social-emotional outcomes. The study found that children who are exposed to high-quality early childhood programs, such as those involving early language and literacy activities, demonstrate significant improvements in their ability to engage with written and spoken language. These programs not only enhance children's language skills but also foster a love for reading and writing, setting a strong foundation for future academic success.

**VOLP** (2013) emphasizes the importance of early intervention in addressing the needs of at-risk children. Through a comprehensive approach that includes parent-teacher collaboration and individualized instruction, VOLP aims to support children's development in all areas, including literacy. The program's success is evidenced by the increased confidence and competence of children in their reading and writing abilities, as well as their improved social skills.

**VOLP Design Features:**

- **Parent Involvement:** Family engagement is a cornerstone of VOLP, with regular meetings and activities designed to involve parents in their child's learning process.
- **Professional Development:** Teachers receive ongoing training to enhance their skills in teaching literacy and to support children's development.
- **Individualized Planning:** Each child's educational plan is tailored to meet their specific needs, ensuring that all children receive the support they require.

**Exposure in VLP:**

- **Elementary School:** Children who participate in VLP show gains in reading comprehension and fluency, which are maintained over time.
- **Secondary School:** Longitudinal studies indicate that students who were part of VLP in elementary school continue to perform better in secondary education, with higher grades and test scores.

**Conclusion:**

The evidence from ProProFact, VOLP, and VLP underscores the critical role of early intervention in promoting children's academic success. By focusing on language and literacy skills, these programs not only enhance cognitive development but also contribute to the overall well-being of children. As such, it is essential for educators and policymakers to invest in early childhood education initiatives to ensure that all children have the chance to succeed.
Medication for Children with SM

Teachers and school staff need to understand the use of PPIs, H2RA, and steroids to prevent gastro-esophageal reflux disease (GERD) and associated symptoms in children with SM. It is also important to ensure that children with SM receive adequate nutrition to support growth and development. Teachers and school staff should also be aware of the potential side effects of these medications and how they may impact the child's behavior and learning.

Future Directions

The study of L-Carnitine in the treatment of SM is ongoing, and new research is needed to better understand its potential benefits. The role of physical therapy and occupational therapy in improving the functional and developmental outcomes of children with SM should also be explored. Additionally, more research is needed to identify the best practices for the education of children with SM in the school setting.
Adapting IT to Treat Anxiety

In Young Children: The PACT CALM Program

Antony S. Dick, Jane M. Furr

Program Description: A PACT CALM

Adapting PACT to Treat Anxiety

Abstract

The PACT CALM program is designed to help children manage their anxiety effectively. This program is specifically tailored for children aged 5-12 years and focuses on teaching coping strategies to reduce anxiety symptoms. The program includes structured activities and exercises aimed at building children's confidence and resilience. By participating in the PACT CALM program, children learn techniques to manage anxiety in various situations, thereby improving their overall emotional well-being.