

Selective mutism: A case study on the use of expressive techniques in assessment and management

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Selective mutism is a relatively lesser-seen psychiatric disorder. In children, the condition might be misdiagnosed as defiant and problem behaviour, putting the child at risk of unwanted and inappropriate management, mostly in school conditions. The present article presented a case of a six-year-old girl diagnosed with selective mutism and associated behavioural problems and intervened with an eclectic approach involving expressive therapy techniques, behavioural therapy, and cognitive behaviour therapy. Structured and non-structured projective techniques were used extensively for rapport building and assessment in the client, who characteristically was mute and non-cooperative in initial sessions. After 12 sessions, a significant change in the client's mute and non-verbal behaviour and problem behaviours were reported. The client was maintaining the progress in subsequent follow-ups.

Keywords: assessment; cognitive behavioural therapy; expressive therapy; psychosocial intervention; selective mutism

Selective mutism is a psychiatric disorder that is usually diagnosed in childhood. According to the latest edition of the Diagnostic and Statistical Manual (DSM-5), selective mutism can be manifested as a consistent failure to communicate verbally in specific social situations where it is required (American Psychiatric Association, 2013). Most symptoms of selective mutism can be seen in the school situation. Selective mutism cannot be attributed to disturbances in language production. Previously, selective mutism used to be categorised under speech disturbances, hysteria, or another neurosis (Kussmaul, 1877) and also as catatonia like impression (Tramer, 1934). The association between anxiety and selective mutism has been taken into account in recent times (Muris & Ollendick, 2015). It has also been seen that selective mutism and anxiety tend to overlap in symptomatology, aetiology, and treatment. Selective mutism can also be demonstrated as the clinically significant presence of features of social anxiety (Cohan et al., 2008).

After latest revisions in DSM-5 criterion of selective mutism, there is a major shift from including anxiety as a symptom in selective mutism to the disorder itself been reclassified as an anxiety disorder as around 80% of individual with selective mutism has co-morbid anxiety symptoms as well (Driessen et al. 2020). Literature suggests that most children with selective mutism also meet the criteria of other anxiety disorders, including lifelong co-morbid anxiety disorder, social phobia, separation anxiety disorder, and generalised anxiety disorder (Oerbeck et al. 2014).

The aetiology of selective mutism involved various factors, including genetics, environmental, temperamental, neurodevelopmental, and avoidance. In the case of anxiety spectrum disorders, the origin of symptom manifestation also includes the factors mentioned above, which encouraged the conceptualisation of selective mutism as a disorder of the anxiety spectrum (Muris 2007).

In accordance with the developmental psychopathology framework, the symptomatology of selective mutism and anxiety disorders could be coincided (Cohan et al. 2006; Viana et al. 2009). A complex interaction between various vulnerability factors increases the risk of selective mutism, among which behavioural inhibition, oppositionality, parental control, and neurological anomalies could concur with selective mutism with anxiety disorders.

Psychosocial intervention for selective mutism aims to decrease conditioned anxiety symptoms and speech difficulties in specific situations. Pieces of evidence suggest that the most effective therapeutic intervention could be done through behavioural and cognitive therapy along with expressive measures. Considering the inclusion of selective mutism in anxiety spectrum disorders, it could be considered the treatment of choice. But the non-anxiety part of the selective mutism, i.e., oppositionality, language difficulties, and other developmental problems, might be neglected and receive less clinical attention. The physiological component of selective mutism includes bodily anxiety symptoms, and expressive therapies encourage children with selective mutism by active physical participation in therapy (Bautista et al., 2018; Fernandez, 2010).

The present article presents psychotherapeutic management of a six-year-old child with features of selective mutism, social anxiety, and behavioural problems.

Case introduction

Index client SP is a six-year-old female, the only child of her parents studying in class 1, belonging to middle socioeconomic status, and hails from an urban locality. At the time of consultation, SP was staying with her mother at her maternal grandparents' place.

Presenting complaints and history

SP was brought for consultation after complaints from school teachers regarding SP's not responding in the class. She had stopped talking with her peers or responding to teachers to the extent that she was not even asking to go for toilet breaks if required. They were not responding to teachers after repeated attempts were gradually construed as defiance, disobedience, and stubborn behaviour, and eventually, her academic performance was getting affected. She was also not mixing with her peers and mostly staying alone in school. The symptoms had a gradual onset in the last six months and had deteriorating progress. Parents reported that they were unaware of this behaviour at school, but she had been avoiding visiting unfamiliar places, getting extremely anxious in social situations with unfamiliar people around. Parents also reported that SP was very capable of speaking and used to speak fluently at home with family members. At home, SP was gradually becoming more irritable, demanding in nature, spending more time watching television and

particular about her food. She was also showing certain defiance if she tried to be disciplined by her mother. The symptoms had a gradual onset in the last six months with deteriorating progress.

Assessment

The child did not speak a single word in the initial sessions and was not cooperative. Initial impressions in the case were based on parental reports and behavioural observation of the child. Rapport establishment was done by inviting the child for games and drawing. A qualitative approach was adopted to understand the underlying issues, and the child could perform the Draw a Person Test. Analysis of the drawing revealed underlying aggression, conflict with parental figures and a high need for succouring. Further assessments ruled out any issues of learning or intellectual disability, or attention deficit.

Even after SP was comfortable enough to sit with the therapist during the initial assessment sessions, the interaction was completely non-verbal as she did not speak a single word if asked. However, with gradually developing rapport, she could respond to queries by making pictures on a sheet, e.g., when asked for 'who are in the family', she drew different figures for self, mother and father. The interpersonal relationship in family and marital discord among parents was expressed only during these non-verbal expressions through drawings and written statements. Further enquiry from parents revealed significant marital discord among parents. Parents never mentioned these issues before unless they were asked specifically and had reported the complaints regarding SP purely as a behavioural and academic problem at school.

Case conceptualisation

SP is a six-year-old only child of her parents. An increasingly growing conflict between the parents had led her mother to shift to her grandparents' place along with SP, where SP's father used to visit her on weekends. She had been witnessing the fights between her parents frequently. SP's parents, especially their father, have modelled being aloof and suppressive of crises and displaying inappropriately irritable and aggressive expressions. The looming threat of separation between parents has led to feelings of insecurity and anxiety in SP, who otherwise had been a cheerful kid. Specific barring from family to not discuss any familial issue outside home led to the development of inhibitory behaviour and gradual withdrawal behaviour from her environment outside the home, i.e., school and friends. Shifting to her maternal grandparents' home and mother made SP more anxious about her parent's separation, and she became more silent outside the home, particularly at school. Repeated reminders from her mother to not discuss the issues outside and her unresolved anxieties appear to have generalised her inhibitions and mute behaviour in school situations and other social situations to avoid the fear of teasing. Finding no one to share her concerns has led to helplessness and suppressed anger, as evident from her projective assessments. The manifestations are becoming mute in front of outsiders and increased defiant and demanding behaviour at home, further reinforced by submission to those demands by mother who was already in a challenging situation. The anxiety of losing the togetherness of their parents had been so intense that she has stopped asking for washroom breaks from teachers. Considering the overall manifestation, an eclectic therapy plan was conceptualised with the following treatment goals: (a) to help SP vent out her anxieties and resume her previous communication and response patterns with people outside the home; (b) to counsel SP's parents to amicably resolve their marital issues, which was having an impact on SP's mental health i.e., plan out this report; and (c) To modify the new-onset behavioural problems of SP.

Course of treatment and assessment of progress

SP was engaged in 12 sessions, excluding the assessment sessions spread across six months. The therapy focused on the selective non-verbal behaviour of SP, her associated excessive anxieties in unfamiliar places and among unfamiliar people, increasing behavioural problems at home and her familial relationship. The therapeutic intervention was emphasised improving SP's communication outside the home along with decreasing her behavioural problems. The mode of psychotherapeutic intervention was primarily expressive in nature through drawings, story-making and writing, and behavioural management.

Rapport establishment. In the primary therapeutic sessions, SP was very shy and resistant to interact with the therapist. After taking a history from their parents, SP was engaged in games which she did after much hesitation without speaking a word. Considering her prior academic performance, block design and colour progressive matrices were presented as game activities to build rapport and estimate the client's intellectual capabilities. Though rapport was established gradually through games, the client was non-verbal throughout the sessions. She became interested in the sessions and was cooperating progressively with the therapist.

Engagement in the activities. The client was engaged in the sessions through verbal and non-verbal information and vocabulary games. Through this process, she became verbally communicative with the

therapist than before. Games were given to her, and she participated in all these activities as well. She became interested and encouraged to perform the tasks which were given to her. Verbal encouragement and reinforcement were given to her throughout the sessions. Tasks like playing and drawing were introduced to her, which increased her overall engagement in the sessions.

Exploring underlying issues and venting out. SP was having difficulties expressing her emotional reactions in unfamiliar situations. The drawing and writing activities helped her vent out her emotional responses in the sessions. Along with unstructured drawing and question answers in writing, projective assessments like the Draw a Person Test and Children's Apperception Test were administered. The tests were administered in a very neutral environment without giving a hint of evaluation to the client. Apart from gaining insight into SP's underlying needs, desires and conflicts, the drawings were also used to understand her neutral and threatening situations. Thus, in this particular case, the expressive techniques had a dual role and a much larger role in rapport building with the client.

Channelling emotions. Cognitive behavioural therapy was used to channel her emotions; and the child's anxieties were explored and desensitised. Rewarding and encouraging were involved in each session. Emotional regulation strategies were used to channel negative emotions, and it had been seen that emotional regulation was improved through sessions. Underlying aggression and anxiety of the child were channelled to more adaptive behaviours.

Reducing behavioural problems. Behaviour therapy techniques were used to decrease behavioural problems in terms of stubbornness and disobedience of the child. Shaping and chaining were used effectively to reduce behavioural problems relative to the recent onset. As the child was gradually developing trust over the therapist, she was in a better accepting mode and amenable to behavioural interventions to schedule and limit her television and mobile screen time, adhering to daily activity scheduling and was better in managing her academic works. Mother was also counselled to accept her demands and ignore unreasonable ones judiciously. Positive changes in behaviour were duly reinforced with verbal praise, timed and assured small gifts like colouring books and crayons.

Targeting familial relationship. A conflicting relationship between parents was conceptualised as a major issue in aetiology of the symptoms; family counselling was involved in the therapeutic sessions to psycho-educate the parents and improve overall disharmony parents. It was also found that the emotional over-involvement of the mother encouraged the discord. Parents were engaged in different counselling sessions.

Social interaction skills training. Social interaction skills training improved the societal functioning of the child. The child started to interact more in school than before. She was assured that her parents are working on their issues, and they cared for her. She was asked about her favourite activities at school and why did she stop them. She was assured that it was perfectly fine to play with her friends and talk with them all. Gradually she resumed her communications initially with her previous close friends as well as her teachers. Initially, she started replying in a hushing tone but gradually was able to speak coherently in mildly low volume. Productivity of speech was lesser, however. She also started communicating her needs in school, and she started involving in peer plays as well.

At the end of 12 sessions, there was a significant change in the client's reported symptoms. SP was much better at verbally communicating outside the home environment and at her school. She was engaging well with her friends and was responding to her teachers though not at a pre-morbid level. She was also expressing her needs with teachers in a much better way. She was still a bit shy in large social gatherings, but better than before. A non-structured rating of change in presenting complaints pre and post-intervention are summarised below:

Complicating factors. The lack of insight on the part of parents, who failed to judge the impact of their behaviour on the child and thought of the behaviour of the child as problem behaviour related to school, was a major issue. While both agreed on the need of addressing their marital discords, there was certain resistance initially to accept this, and they failed to mention it at the very beginning. However, they agreed for undergoing counselling for their marital discord, which is still in process with an uncertain outcome, though expected with a positive prognosis.

Access and barriers to care. The major resistance or blocks experienced in the therapy process were extreme non-cooperation on the part of the child for rapport building. Characteristically to the symptom pattern of her diagnosis, the child was completely mute in initial sessions and started crying if separated from her mother during the session. It was not easy to get engaged. To counter this, interest areas of the child were explored and accordingly, she was invited to solve puzzles, play block games and time-bound

games. Verbal appreciation and praise on performance motivated her to further engage in the activities and break the ice.

Follow up. She had been under follow up once every month for the next four months. After enforcement of lockdown due to the COVID-19 pandemic, follow-up sessions were done through video calls.

Treatment implications of the case

Presentation and assessment. The presentation of the symptoms in selective mutism in children is often misconstrued as wilful problem behaviour and conduct problem as in the present case. Family members might present their concerns differently, while the underlying issues might be something different (Halder & Mahato, 2019; Srinath et al., 2019). Thus, it is of paramount importance to explore every aspect of the clinical history. Family members might be unknowingly secretive of certain familial issues that impact the symptom manifestation, thus needing to be explored thoroughly. The symptom presentation in the present case is in line with existing literature on selective mutism. In the case of the present child, the social anxiety and the avoidance of unfamiliar situations appeared to be prevalent among children with selective mutism, and indeed researchers suggest that Selective Mutism could be explained as a symptom manifestation of social phobia (Black & Uhde, 1995) or anxiety disorder (Anstendig, 1999). The index child had symptoms of disobedience, uncooperativeness and stubbornness, which are common among selective mutism (Kristensen, 2001). Externalising symptoms are reported twice as frequent among children with selective mutism, and avoidant behaviour of the child may be misinterpreted as manipulative or controlling where it is a more symptomatic manifestation of shyness or anxiety (Kristensen, 2000).

The aetiology of selective mutism is quite heterogenetic, and multiple factors are implied. Psychodynamic theories are one of the oldest theories implied in the aetiology of selective mutism. Although, recent literature, (e.g., Wong, 2010) cast doubt on the validity of the model; in the present case, the perceptible relation between the client's anxieties and the onset of her symptoms emphasises the role of unresolved conflicts and possible lack of coping strategies of the child to deal with her anger and anxiety. The case background also supports family system theorists, who often view SP as a product of conflicting familial relationships (Anstendig, 1998).

As the primary symptom itself make the clients relatively non-responsive compared to clients of other disorders, use of expressive techniques and structured as well as unstructured projective techniques for rapport building and assessment is suggested in the literature (Bhide & Chakraborty, 2020; Capobianco & Cerniglia, 2018), and was effectively used in the present case. It was evident from this case that in selective mutism, assessments may not be strictly very structured and, depending on cooperativeness, can be timed afterwards.

Considering the heterogeneity of the symptoms, an eclectic approach in selective mutism is often recommended. Recommended therapies include psychodynamic therapy, behavioural therapy, cognitive behavioural therapy, pharmacotherapy, and multi-method treatment (Wong, 2010). The eclectic psychotherapeutic treatment of selective mutism, including psychodynamic play therapy, behavioural modification, and cognitive-behavioural approaches, appears to be most effective for children with selective mutism (Cohan et al., 2006). The therapeutic approach adopted for the present case included components from expressive therapy, behavioural and cognitive behavioural therapy and family counselling, and asserting the need for customised therapy plans for every case of selective mutism.

It was perceptible that parenting strategies, parental adjustment, and general family environment could lead to a different spectrum of psychological issues in children. Through an integrative approach to the child's symptomatology, the presenting complaints, including mutism, social anxiety and avoidance, interaction, uncooperativeness, behavioural problems and social relationship of the client, were improved.

Recommendations to clinicians and students. Selective mutism is a unique disorder, and the heterogeneity of underlying causes warrants a thorough understanding of familial interpersonal relationships, anxiety and conflicts of the client. The underlying anxieties and fear witnessed by the client; in this case, support the overlapping of anxiety disorders and selective mutism symptoms. A multi-model and eclectic approach for the treatment of selective mutism is recommended. Rapport building is vital in dealing with clients with selective mutism, and expressive and non-verbal techniques could be vital in psychological assessment and therapy.

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