

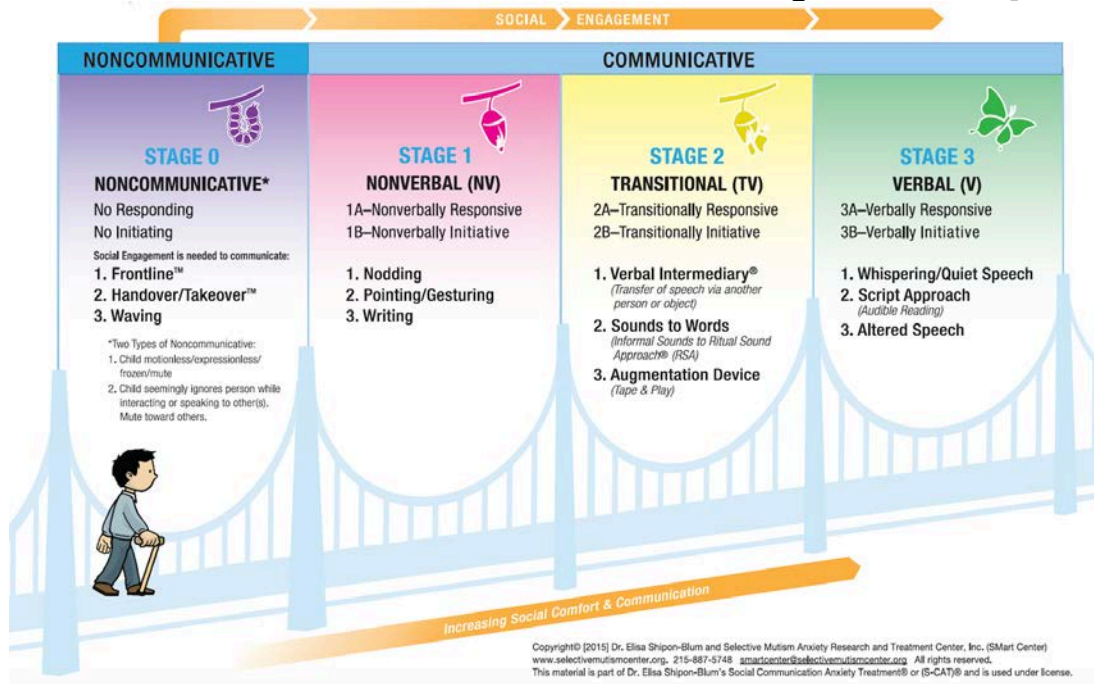


Social Communication Anxiety Treatment® (S-CAT®)

Transitional Stage of Communication (Stage 2) The Missing Link!

By: Dr. Elisa Shipon-Blum

The Social Communication Bridge®



Children with Selective Mutism present in a variety of different ways. Some children can be shut down and noncommunicative (Stage 0 on the Social Communication Bridge®) while others can become comfortable but use nonverbal means of communicating, such as pointing, gesturing or nodding, etc. (Stage 1 on the Social Communication Bridge®). Some children can whisper or speak quietly to select others while remaining mute with these same individuals in a different social setting (Stage 3 on the Social Communication Bridge®)!

Therefore, no two children with SM are the same in terms of their social communication skills. For the typical child with SM, not implementing strategies and interventions while the child feels an expectation to speak only reinforces the child's anxiety. The child will remain 'stuck' in nonverbal communication.



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

Answer: The reality is that comfort alone is often not enough to prompt speech. In fact, unless the proper strategies and interventions are in place, the child often remains nonverbal or progress can be quite limited, especially if the child feels people want him/her to speak.

Question: For the nonverbal child, is lowering anxiety enough to stimulate speech?

Answer: For the majority, the answer is NO, especially as a child ages. For the child who can respond via nodding, gesturing, pointing, writing, etc. he/she may appear comfortable, relaxed and engaged, yet mutism persists.

Question: If anxiety is low, and the child appears comfortable, why does he/she just talk?

Answer: 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 he/she does not speak, reinforced mute behavior persists.

The child with SM is often stuck in the nonverbal stage (Stage 1 of the Social Communication Bridge®) 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 in which children, specifically those with speech phobia, who are verbal in all or most settings remain mute in one or a select few locations. For example, the child who is mute in the classroom but outside 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 in this case is specific to school.

The saying, "*So close, but so far*" is more appropriate for most 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).

Question: How then, do you get a child to speak if lowering anxiety is not enough?

Answer: 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 for structured ways for parents and children to unlearn conditioned behaviors will not be successful. For the mute child, if focus is on in-office therapy without implementation of strategies outside the office, treatment resistance will often occur.



Question: Are there specific transitional strategies?

Answer: Yes! There are thousands that can be categorized into the following:

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® by whispering into that person's ear or communicating the Verbal Intermediary® in front of the other person. The child's unique characteristics will dictate how incremental they 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 Verbal Intermediary® up close, e.g. a fist length away, etc. There are some children who may need to start outside of the room, using an adjunct to begin, such as a tape recorder. There are many different measuring means and methods of using a Verbal Intermediary®. The point is, the child has a controlled way of transitioning.

When facilitating the child to use a Verbal Intermediary®, I suggest using directive language with a choice question; e.g. "Do you like red or yellow? Tell _____." Then the individual who asked the question repeats (even if barely audible) without eye contact. Using directive language provides your child with confidence.

2. Sounds to Words

The child enters speech via the backdoor approach. This can be done via an informal approach of using phonetics with younger children. Visuals of letters, imitation, etc. where the child begins to phonetically put sounds together to make words. The use of phonetics is often subtle and does not always involve a cognitive approach. However, when working with children using the S-CAT® approach, using the Bridge® and showing the child his/her location as they move across the Bridge® is recommended.

For older children, esp. those who are 'stuck' yet comfortable from a nonverbal standpoint, a cognitive approach is used to help the child think of sounds from a mechanical standpoint. For most 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 transitioning speech. This approach is referred to as the *Ritual Sound Approach® (RSA®)*. Charts are developed under the guidance of a trained S-CAT® clinician, but the child chooses:

- the sounds of choice
- how the sounds are made
- the order in which the sounds are made



- which sounds to put together to make words
- with whom the child will make sounds to words
- where the sounds to words are made
- what questions are asked

Using the child's feelings chart to help guide the process provides the child added control and is highly recommended. Some children need to start via nonverbal means of tapping as a representation of "yes" and "no" (i.e., 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 breath in/out), "S" (pushing air through 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. Augmentative Devices, (e.g. tape recorder)

Some children are fine with others hearing their voice. Other children are terrified and/or simply resist. Do not push a child into taping his/her 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 tape 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 is 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 that the child can play in front of the teacher/select peers or to provide the teacher for assessment).

Conclusion

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 Social Communication Bridge®. 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.

Each child has a unique recipe. Although many recipes start out with similar ingredients, the way the ingredients are used will dictate the result or successful response to treatment!



To effectively overcome Selective Mutism and all anxieties, a child needs to be involved in a treatment program, such as the evidenced-based [Social Communication Anxiety Treatment® \(SCAT®\)](#). Developed by [Dr. Elisa Shipon-Blum](#), this holistic or "whole child" treatment approach is designed to reduce anxiety, build self-esteem, increase social comfort and communication in all settings.

As a physician, Dr. Shipon-Blum views SM as a social communication anxiety where mutism is merely a symptom. The key to an effective treatment plan is understanding factors into the development and maintenance of SM as well as understanding a child's [baseline level of social communication](#). Then, working as a team, the treatment professional, parents, and school staff members help the child build coping skills to combat anxious feelings and to progress across the Social Communication Bridge®. Visit www.SelectiveMutismCenter.org more information.

Part of Social Communication Anxiety Treatment (SCAT®)