ASSESSMENT in SPEECH-LANGUAGE PATHOLOGY

A Resource Manual

Sixth Edition

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Preface

Assessment in Speech-Language Pathology: A Resource Manual, Sixth Edition offers students and professionals user-friendly information, materials, and procedures for use in the assessment of communicative disorders. Many reproducible forms, sample reports, and quick-reference tables are provided. Materials published previously, but unavailable in a single source, as well as materials developed specifically for this work are included.

Beginning with the inaugural edition of *Assessment in Speech-Language Pathology: A Resource Manual*, which was first published in 1992, the authors have strived to provide readers with information that is current, relevant, and practical. Every edition has been thoroughly reviewed and updated to provide accurate and applicable information to reflect current practice in our ever-changing profession. This latest sixth edition is no exception. New to this edition:

- New chapter on selective mutism
- New content on transgender voice assessment
- New pictures for eliciting speech-language samples
- Reorganized and updated content related to acquired neurogenic language disorders and speech disorders
- Expanded content on medical conditions associated with communicative disorders
- New images related to hearing considerations, including updated sample tympanograms, audiograms, and the speech banana
- New tables throughout to improve ease of understanding content
- Chapter-by-chapter content updates to reflect current research and practice
- Updated and new recommendations for published assessment tools, sources of additional information, online resources, and apps useful for assessment
- Online access to downloadable forms and PowerPoints lecture slides
- Upgraded soft cover with layflat binding for book longevity and ease of use

Assessment in Speech-Language Pathology: *A Resource Manual, Sixth Edition* is divided into four major sections. Part I highlights preparatory considerations. Psychometric principles are summarized, including standardization, validity, and reliability. Descriptions of norm-referenced testing, criterion-referenced testing, and authentic assessment are provided, including advantages and disadvantages of each approach. Preparatory considerations when working with multicultural clients are described as well.

Part II includes procedures and materials for obtaining assessment information, interpreting assessment data, and reporting assessment findings to clients, caregivers, and other professionals. It also includes a range of interpretive information, interview questions for various and specific communicative disorders, and guidelines with examples for collecting or reporting assessment information.

Part III provides a variety of materials and suggestions for assessing communicative disorders. Chapter 5 includes general assessment procedures, materials, and worksheets common to all disorders. The remaining chapters are dedicated to specific communicative disorders. Each contains a variety of reference materials, worksheets, procedural guidelines, and interpretive assessment information specifically designed to address the unique characteristics of each disorder.

Part IV provides additional resources relevant and helpful for assessment. It includes audiometric principles that are among the expected competencies of speech-language pathologists as they pertain to communicative development and function. It also includes definitions and clinical relevance of many medical conditions, diseases, and syndromes associated with communicative disorders.

Each chapter includes a listing of "Sources of Additional Information." Because the Internet is a dynamic environment, some sites may no longer exist or may have changed in content. Apps appropriate for speech-language assessment are also recommended. Again, this is a burgeoning industry and continually changing. Consider the recommended resources listed in this text a springboard for exploring additional books, websites, and apps for diagnostic purposes.

Purchase of this textbook includes digital access to the content through the PluralPlus companion website. Forms found throughout the text are available in downloadable format to meet individual clinical needs. Many of the stimulus materials used for assessment are also available, including storyboard art, illustrations, and reading passages. These can be used in their digital form or downloaded and printed. Clinicians are encouraged to download content onto a flash drive or other portable storage device so that they have access to these files if they work in environments where Internet access is not readily available.

Assessment in Speech-Language Pathology: A Resource Manual, Sixth Edition can be a valuable resource for beginning or experienced clinicians. No other manual provides such a comprehensive package of reference materials, explanations of assessment procedures, practical stimulus suggestions, and hands-on worksheets and screening forms.

Chapter 9

Assessment of Selective Mutism

- **Overview of Assessment**
- **Characteristics of Selective Mutism**
- **Behaviors Associated With Selective Mutism**
  - The Negatively Reinforced Avoidance Pattern
- **Importance of Early Identification**
- **Assessment of Current Speaking Behaviors**
- **Assessment of Social and Emotional Status**
- **Assessment of Speech and Language**
  - Creating a Low-Anxiety Setting
- **Making a Diagnosis**
- **Concluding Comments**
- **Sources of Additional Information**
  - Print Sources
  - Electronic Sources
- **Chapter 9 Forms**

This chapter provides an overview of selective mutism, possible co-occurring disorders, assessment procedures, and guidelines for diagnosis.

Overview of Assessment

History of the Client
- Procedures
  - Written Case History
  - Intake Interview
  - Information From Other Professionals
- Considerations
  - Medical or Neurological Factors
  - Hearing
  - Developmental History
  - Age and Gender
  - Family History of Anxiety Disorder
  - Home Environment
  - Primary Language and Culture
  - Motivation and Level of Concern

Assessment for Selective Mutism
- Procedures
  - Screening
  - Consultation With Parents or Caregivers
  - Consultation With Other Professionals
  - Formal and Informal Testing
  - Direct Observations
- Analysis
  - Current Abilities
  - Avoidance Behaviors
  - Situational Demands
  - Co-occurring Disorders

Speech Assessment

Language Assessment

Voice Assessment

Stuttering Assessment

Orofacial Examination

Determining the Diagnosis

Providing Information

Characteristics of Selective Mutism

Selective mutism is an anxiety-based communication disorder of childhood characterized by an inability to speak in some settings, despite an ability to speak in other settings. If untreated, selective mutism can continue through adulthood and have a significant negative impact on social, academic, and occupational success. All cases of selective mutism include the following five features:

1. A consistent failure to speak in specific social situations in which there is an expectation for speaking, despite speaking in other situations.
2. The failure to speak interferes with educational or occupational achievement or social communication.
3. The behavior lasts for at least 1 month (not counting the first month of school or new setting).
4. Failure to speak is not due to lack of proficiency or comfort with the expected language.
5. The behavior is not better explained by another disorder, such as a speech-language disorder, autism, hearing loss, learning difficulty, or other psychiatric disorder (American Psychiatric Association, 2013).

Other characteristics and facts about selective mutism include the following:

- Selective mutism is fear based.
- It is correlated with a physiological response in the brain, which signals danger.
- It is associated with a family history of anxiety disorders.
- It may or may not co-occur with another deficit, such as a speech-language disorder, autism, learning disability, or other anxiety disorders.
- Onset is usually between 3 and 6 years of age, when the child begins school.
- It occurs equally across ethnic populations.
- It is more common among bilingual and immigrant children.
- It is more common among females.
- It is more common among children who are highly sensitive, shy, timid, perfectionistic, controlling, or bossy.
- It is more common among children with above-average intelligence.
- A child with selective mutism may think his or her voice is unpleasant or scary.
- Selective mutism is *not* extreme shyness, stubbornness, or defiance.
- It is *not* a result of neglect or trauma.
- A child will *not* naturally outgrow selective mutism.

The cause of selective mutism is unknown. It is probably rooted in family history, individual temperament, and environmental factors that influence each other over the course of time. Some children are predisposed to selective mutism due to genetic factors, personality characteristics, speech-language difficulties, learning disabilities, or psychiatric conditions. Early risk factors, noticeable as early as age 1, are extreme shyness, fear of novel people, hiding, and reluctance to speak in some settings.

Behaviors Associated With Selective Mutism

The most typical example of selective mutism is a child who speaks normally at home but is unable to speak at school. The parents are surprised that their child is not talking at school, because the child talks freely in other settings and is otherwise developing normally. This example, while most typical, does not include the range of possible profiles. In less common examples, the child speaks comfortably at school but not at home, the child speaks at school but only in a whisper and through an intermediary, the child speaks to only one parent regardless of the setting, or other scenario. In some cases, the child's the selective mutism is so severe that he or she is completely unable to communicate using any means. This child may appear frozen with a deer-in-the-headlights expression. Other children can communicate but through alternative methods. For example, the child may communicate by:

- Using gestures such as pointing, miming, or head nodding or shaking
- Drawing or writing
- Whispering
- Using only single words or short phrases
- Adopting an altered voice
- Using a language only certain people in the environment understand
- Speaking through an intermediary, usually whispering to the intermediary who then shares the message out loud

Selectively mute children tend to adopt strategies to escape or avoid fear-inducing speaking situations. For example, the child may:

- Physically leave the speaking situation
- Freeze in place, as if invisible
- Avert eye contact
- Grow long bangs to cover the face
- Hide
- Cling to a parent
- Cry
- Refuse to get dressed for school or other activity
- Throw tantrums
- Refuse invitations to social events
- Acquire a psychosomatic illness, such as a stomach ache or headache

The Negatively Reinforced Avoidance Pattern

Selective mutism is often maintained and strengthened through negative reinforcement of the child's avoidance behaviors. When the child is confronted with an anxiety-inducing communication situation, either immediately or anticipated (e.g., before leaving for school), the child's likely response

is to avoid the situation. The avoidance behavior postpones or ends the pressure to talk. The next time an anxiety-inducing communication situation presents itself, the child is more likely to repeat the avoidance behavior.

A second type of negative reinforcement occurs when a caring and good-intentioned person (usually a sibling, parent, or teacher) steps in to rescue the child from the anxiety-inducing communication situation. The child is unable to talk in the expected situation, which results in a social awkwardness felt by everyone present. The rescuer ends the awkwardness by speaking on the child's behalf. All involved immediately feel better; however, the child's anxiety and avoidance response is negatively reinforced by the good-intentioned rescuer. In the next speaking opportunity, there is an increased likelihood that the child will avoid again and allow a rescuer, either the same person or someone else, to "save" him or her. This pattern becomes more and more engrained with repetition.

Figure 9–1 depicts these two versions of the negative-reinforcement model. It is important to understand that parents, or other rescuers, do not *cause* selective mutism. But it is also important to understand how this cycle of negative reinforcement can contribute to the maintenance of a child's selective mutism.

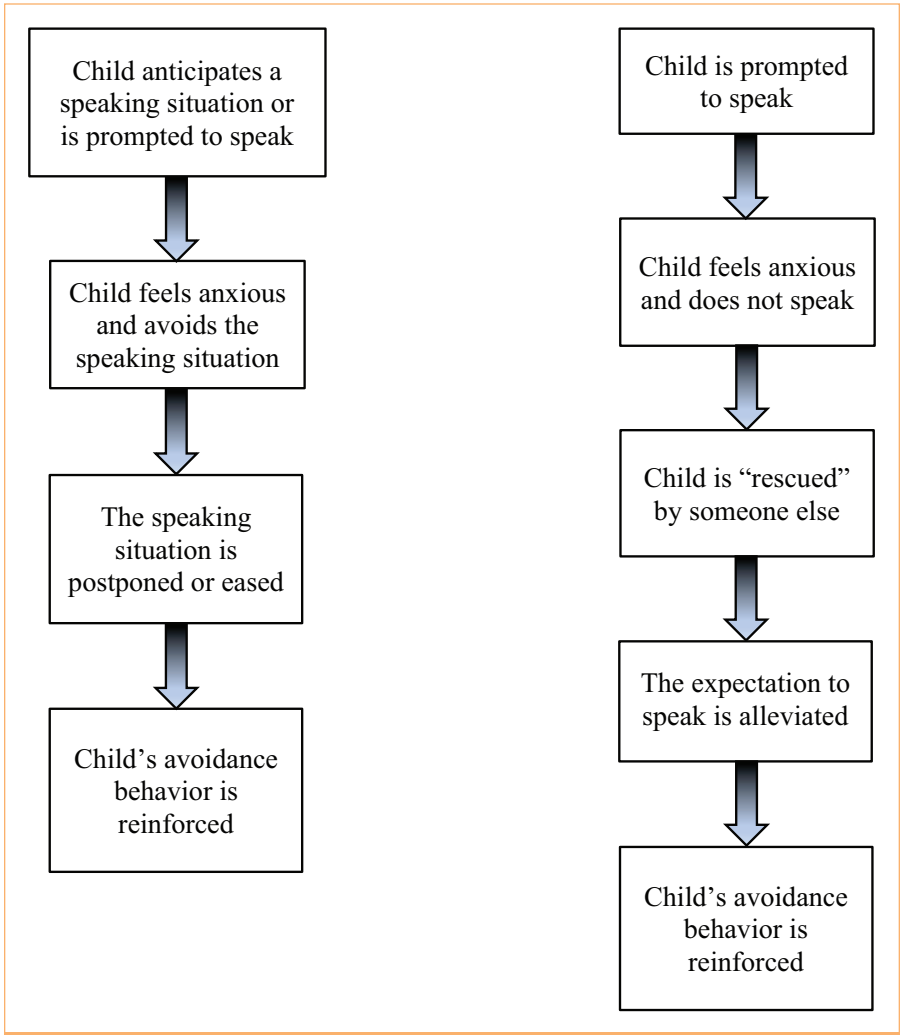

FIGURE 9–1. Two Negative Reinforcement Models of Selective Mutism.

Importance of Early Identification

It is advantageous to identify selective mutism as early as possible. Early intervention can prevent the compounding effects of nonintervention. For example, the child with selective mutism is not fully benefiting from language-learning experiences, which may worsen a preexisting language disability. The child's fears may develop into other serious psychological conditions, such as clinical depression or withdrawal. Also, the avoidance behaviors associated with selective mutism become more difficult to resolve without early intervention.

Unfortunately, many children are not evaluated for selective mutism until several years after the onset of symptoms. This usually happens because the behavior is not understood and assumed to be something the child will outgrow. Assessment and early identification usually involve a team approach. Members of the team might include the speech-language pathologist, child's parent(s), classroom teacher, school administrator, school counselor, psychologist, psychiatrist, social worker, and/or pediatrician. The speech-language pathologist has the primary role of identifying the child's speech-language abilities and deficiencies. In some cases, the speech-language pathologist also has the primary role of diagnosing selective mutism and educating family and school personnel about the importance of early identification and intervention.

Assessment of Current Speaking Behaviors

Selective mutism cannot be diagnosed or ruled out without a thorough understanding of the child's speaking abilities. Find out *who*, *what*, *where*, *when*, and *how* through interviews with the child's parents and classroom teacher and through direct observations. Obtain a thorough picture of what the child is and is not able to do to communicate. Determine how the child's communication varies depending on the audience, environment, and speaking situation.

- *Who* does the child talk to and not talk to? For example, the child talks freely to parents; the child talks to one friend at school; the child only talks to a household pet; the child does not talk to men; the child does not talk to the teacher.
- *What* entices the child to talk or causes the child to fail to talk? For example, the child talks while playing with blocks; the child talks if self-initiated; the child answers yes/no questions but fails to answer open-ended questions; the child fails to talk during structured class time.
- *Where* does the child talk and fail to talk? For example, the child talks on the playground; the child talks in the car; the child does not talk in public; the child does not talk at school.
- *When* does the child talk and fail to talk? For example, the child talks when no one is watching; the child talks one-on-one with the listener; the child talks when a parent is present; the child does not talk when an unfamiliar adult is present.
- *How* does the child communicate? For example, the child communicates with gestures; the child uses rote phrases; the child whispers to an intermediary; the child freezes and is unable to communicate.