SPECIFICS OF THE PROCESS OF PSYCHOLOGICAL ASSESSMENT OF A CHILD WITH SELECTIVE MUTISM: CASE STUDY

PARTICULARIDADES EN EL PROCESO DE EVALUACIÓN PSICOLÓGICA DE UNA NIÑA CON MUTISMO: PRESENTACIÓN DE UN CASO

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Abstract

Selective mutism is a relatively rare anxiety disorder, expressed in the inability for verbal communication in specific situations, despite the otherwise good speech abilities. It can lead to an expressed social dysfunction and very often children at school are not able to reveal their potential and are ignored and their needs neglected. With age, the traits of the disorder become more sustainable and resistant which necessitates their early identification and involvement of the children in the relevant therapeutic interventions. The interventions themselves are only efficient when based on the potential and abilities of the specific child, for the purpose of which a psychological assessment is necessary. The present article presents the specifics of the process of psychological assessment of a girl with SM.

Key words: Selective mutism, psychological assessment, cognitive abilities, intellectual functioning.

Resumen

El mutismo selectivo es un trastorno de ansiedad relativamente raro que resulta en la incapacidad para llevar a cabo la comunicación verbal en situaciones específicas contra una buena capacidad de habla. También puede conducir a una disfunción social, con lo cual a menudo niños en edad escolar no son aptos a demostrar su potencial y se ven ignorados y sus necesidades descuidadas. Con el avance de las edades características de la enfermedad se convierten más estables y resistentes, lo que impone su identificación temprana y la inclusión de los niños en unas intervenciones terapéuticas relevantes. Las intervenciones son eficaces cuando se basan en el potencial y las posibilidades del niño en particular, para cuya definición es necesario un estudio psicológico. En el presente artículo exponemos las peculiaridades del proceso de examen psicológico en una niña con MS.

Palabras clave: Mutismo selectivo, evaluación psicológica, habilidades cognitivas, funcionamiento intelectual.

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INTRODUCTION

In the last decade in a number of European countries there is increase in the requests for use of mental health services for children and adolescents, which requires the generation of new resources (financial and human), as well as adaptation of the work pattern to the modern world standards (Tick, van der Ende y Verhulst, 2008). The efforts of the professionals are directed towards early identification and the relevant study of the so-called risk groups, with an emphasis on the group of children and adolescents demonstrating nervous developing problems and those with behavioral problems. Unfortunately, regardless of the increased demand for mental health aid, a number of studies show that only a small part of the children with emotional and behavioral problems are covered by the consulting specialists on time – 14-16% (Frigerio et al., 2009) to 20-25% (Sourander et al., 2003), which preconditions a risk of deepening of their problems and therefore requires an analysis of the causes thereof and solutions for its overcoming. The recommendations are focused on the improvement of the training of specialists working in the educational, social and
health system, as well on the sharing of practical experience, which is achievable through the presentation of challenging cases and their analysis.

In the present paper, we discuss some of the challenges which the psychologist faces in the course of psychological assessment of children with selective mutism, illustrating this by a presentation of a specific case. The significance of this topic comes from the fact that on the one part the information on the mental diagnostic assessment of children with this diagnosis in the specialized literature is sparse and on the other part, the perspective for development of children with selective mutism would be more favorable if they receive timely and adequate support, which requires knowledge of their cognitive, socio-communicative and emotional abilities and needs.

**Selective mutism**

Selective mutism is an anxiety disorder which may lead to an expressed social dysfunction. The functioning of a child with mutism is connected with complete silence in at least one specific social situation, with full ability for verbal communication in another (Bergman, Placentini & McCracken, 2002). The serious discrepancy between speaking in a domestic environment and keeping silence in the kindergarten, at school or other public places is indicated as its main characteristics (Bergman et al., 2002). This type of behaviour has long been regarded as the personal choice of the child. In the last years, the specialists’ opinion has changed and the idea of the anxiety of the child was highlighted in the preferred explanatory model. This approach lies at the foundation of the change reflected in DSM-5 (DSM-V, 2013), where mutism is removed from the group of Disorders of social functions first diagnosed in infancy, childhood, and adolescence and is placed in the group of anxiety disorders. It is indicated therein that this diagnose may only be given if there are five diagnostic criteria fulfilled. The first one is related to the already described child’s failure to speak in specific social situations where it is expected to happen, although he/she speaks in others. The second one relates to the effect, which such a disturbance has on the educational achievements and social communication, and the third one concerns its duration (at least 1 month), excluding the first month at school. The following two criteria clearly outline that SM cannot be explained with the availability of a cognitive deficit, a problem connected with the language used in the relevant social situation or the availability of communication disorder. In this revision of classification it is outlined that the expressions of SM may not be regarded as such if they only occur in the context of Autism Spectrum Disorder, schizophrenia or another psychotic disorder” (APA 2013, p. 195).

Since SM is a comparatively rare disorder, it is not included in large-scale epidemiological studies related to mental health problems (Mental Health Foundation, 2007) and the epidemiological data connected thereto are relatively scarce. Research shows spreading of 0.02% - 0.05% (Goodman, Scott, & Rothenberger, 2007) to 1.9% (Kopp & Gillberg, 1997) and 2.0% according to Kumpulainen, Räsänen, Raaska, & Somppi, (1998). It is registered comparatively more often among children from migrant families – 7.9 per 1000 (Dummit, et al., 1997), 2.2% (Elizur, & Perednik, 2003). Those data should be regarded through the prism of the relative “harmlessness” of the silence of children with SM, which is the reason for the timely search for help and for its more difficult recognition by the specialists, who review its expression as a serious form of shyness rather than a serious diagnostic category (Kopp & Gillberg, 1997; Schwartz, Freedy & Sheridan, 2006). The above-described cases, as well as our experience, show that most often parents seek specialized aid when the child starts school, after more than 2-3 years of silence and under an already established behavioral model. It is considerably more often seen in girls, but those differences are relative with a view to the small number of studies and a few excerpts provided therein (Wong, 2010). The duration of the disorder has a similar pattern and varies from several months to years (Krysanski 2003). However, there are preconditions to believe that most often the SM symptoms persist in the course of development of the child, its resistance increases and this makes the therapeutic process extremely difficult (Standart, & Le Couteur 2003), especially when it is belated.

**Psychological assessment and SM**

Specialized literature provides multiple advice and recommendations related to the psychological assessment of children, adolescents, and adults with typical development or different diagnoses, but the information regarding children with SM is scarce. Despite the specifics of this disorder, it is assumed that within the diagnostic assessment of a child with mutism, the general standards applicable in the psychologist’s practice must be observed, and more specifically those related to children with emotional and behavioral problems.

In line with the contemporary models of work, the psychological assessment should be regarded not merely as an opportunity for identification of a problem or problematic area, measurement of opportunities and achievements, but also as a dynamic process influencing not only the child but also its relatives, or as a natural transition to or from a therapeutic intervention (whenever necessary). In children with SM it is especially notable as the limited verbal communication channel and the impeded communication in general, require both the provision of more time for the assessment itself (the period of adaptation is extended, the child needs more
time for preparation), and involvement of interventions facilitating the contact, which are therapeutic in their essence.

The specialist is expected not only to help the child adapt to a new environment or the presence of an unknown adult but also to adjust his/her approach and the assessment procedures to the specifics of the child. Where the assessment process involves other persons, as it frequently happens with children with SM, who are not able to separate from their parents, the challenges become even bigger. On the one part the relatives, performing the role of mediators in the process of communication with the child, facilitate the performance of test tasks and the conduct of an interview but on the other part, their presence often requires the specialist to take care of them too (their emotions, experiences, inquiries, etc.). At the same time the opportunity to observe the interactions between the parents and the child in different situations (structured, semi-structured and free play), provides valuable information not only about the functioning of the child but also for the models of communications, coping strategies used by the family and its resource in general. This also enables the achievement of a working union with the parents which is very important for the reduction of their resistance and the provision of better understanding and a higher level of collaboration.

The parents’ readiness for cooperation also enables the access to other points of view for the child or the application of the model of the so-called multi-informative assessment. This type of assessment allows people with different roles and prospects to share their personal impressions of one and the same examined child/adolescent, acquired at different times and within different contexts. This is a growing tendency for obtaining information through the use of several separate tools and the provision of different informants (child, parent, teacher, etc.), which is especially efficient in children with SM.

Currently there is no strictly defined standard set of tools for psychological assessment of children with SM (and also of children with developmental and/or emotional problems), most frequently the used set of tools and methods is a result of the individual (or team, institutional) preferences and estimates of the researcher himself, who also determines the procedure, basing its arguments on the needs and abilities of the specific child, its relatives, on his own preparation, training, experience and financial resource, of course (Carbone et al., 2010; Oerbeck et al., 2016). Although the multi-informative assessment proves to be a preferred model of assessment of children and adolescents with problems in the emotional and/or behavioral regulation for many reasons, its realization has certain specifications which should be taken into consideration (Kristensen, 2001; Jacob Marni, Suveg, & Shaffer, 2013; Oerbeck et al., 2016; Carbone et al., 2010). While the examination of adults mostly relies on self-assessment questionnaires, the work with pupils requires the application of such type of tools which provide information from adults connected to the child itself such as parents, teachers or other relatives familiar with its development and everyday life. The preferred rating scales for this purpose are also applicable in the assessment of the behavior and emotions of children with SM (Shriver, Segool, & Gortmaker, 2011; Wong, 2010). They have different forms of filling in, including by the child itself. However, there should be considered the risk that it may not possess the expected educational, cognitive or motivational capacity necessary for the application of self-assessment tools. It is assumed that children up to the age of 9 are very unlikely to be able to describe themselves in an adequate manner when working with self-assessment scales, as to this end they need a certain level of language and cognitive competence pertaining to the understanding of the target dimensional categories in the specialized tools, which in most cases are available only at the age of 11. In the described cases and articles the following tools are outlined: School Speech Questionnaire (SSQ) (Bergman et al. 2002), Selective Mutism Questionnaire (SMQ) (Bergman et al. 2008), Social Phobia and Anxiety Inventory for Children (SPAI-C) (Beidel, Turner, & Morris, 1995), and the Anxiety Disorder Interview Schedule for Children and Parents (ADIS-C/P) (Silverman, & Albano, 1996).

This poses another aspect of the psychological assessment of children with SM, namely the assessment of their academic achievements, cognitive abilities, and intellectual functioning. The silence of the child in the kindergarten or at school impedes the access of the teachers to the child’s knowledge and often raises questions as regards to the degree of the child’s ability to understand and assimilate the provided information. It is exactly this uncertainty that causes the child to be sent to the school psychologist or to another specialist in other spheres of the educational, social or health system, which happens much more often to children with mutism in comparison to their peers (Bergman et al. 2002; Bergman 2012). One of the most frequent questioning patterns is related to the level of intellectual functioning. Wechsler Intelligence Scale for Children (WISC) (Wechsler, 2014), which is the golden standard in the assessment of the intellect of the children, consists of the verbal and non-verbal part. The application of tests and questions in children with mutism is very difficult and the results thereof require careful interpretation.

The high level of comorbidity which is registered with children with SM often confronts the psychologist with tasks related to the differential diagnosis and the application of specific clinical tools. For example, with a view to the reported similar manifes-
tations in children with Autism spectrum disorders, literature points out the application of Autism Diagnostic Observation Schedule (ADOS) (Lord et al., 2012) and the Autism Diagnostic Interview-Revised (ADI-R) (Lord, & Rutter, 2003) or other similar tools.

The assessment of children with SM also involves video recordings provided by the relatives, which present the child in its daily domestic environment where it speaks freely. Such recording allows for indirect assessment of the child’s language skills.

Irrespective of the choice of the methods of assessment, the main principle which should be observed when assessing children with SM, is the application of the model of the so-called biocological approach (Bronfenbrenner, & Morris, 2006) which allows for the creation of an overall picture of the child and not separate spheres of its development, with this picture becoming clearer and more discernible when the psychological assessment is part of the team assessment of the child with SM.

CASE STUDY

In the case presented by us, we focus on the psychological assessment of a child at primary school age, who is later diagnosed with SM. The assessment was carried out at the Clinic of Child Psychiatry “St. Nikolas”, within the context of a multidisciplinary clinical assessment, involving child psychiatrist, clinical psychologist and speech therapist and covers the period October – November 2016. The child’s names, as well as other data which allow for her identification, have been changed or excluded in order to preserve the confidentiality of information.

Reasons for consulting and application for psychological assessment

Mina has turned 8 when her parents tried to arrange a consultation with a psychologist. They have been directed by her teacher, who even at the beginning of the previous school year expressed her anxiety about the child and more specifically about the fact that she does not talk with her or with her classmates. The lack of verbal communication with the girl, in the teacher’s opinion, impedes her adaptation at school and thought it couldn’t be explained with cognitive and/or speech deficit, such may not be excluded until a psychological assessment is made.

Data after consultation with a psychologist and child psychiatrist:

Purpose: an assessment of the cognitive abilities, behavior, socio-communicative skills and emotional condition.

Methods: interview with the parents and the child; observation of the behaviour in an individual context of work in the presence of a parent/s and individually; diagnostic group (2 sessions in a group with another child); review of documentation and video materials; Strength and Difficulties Questionnaire- a form for children, parents and teachers (Goodman, 1997); WISC-IV; ADOS; drawing tests; play sessions.

Timeframes: the psychological assessment was carried out within 10 sessions with duration between 40 and 50 min. each.

Family and family environment

Mina is the only child in the family. Her parents have been married for 10 years. They are 35, with a successful business in the field of economics, with comparatively high social status, but with limited social life. Mother: “We both work a lot... we communicate with many people every day. Outside of work we try to spend time together”. They live in a home near the mother’s parents who also take part in the raising of the girl, whenever necessary. The father’s parents live in the country and they don’t meet often. The family usually travels during the weekends - “We go wherever she wants to go. This is our way to make her important”.

History and development of first worries – according to data provided by the parents and on the basis of the documentation.

Mina was born from first pregnancy without complications. She was born with planned section cesarean close to the term. She was breastfed up to the 30th month. Mother: “I could have breastfed her even more but when she was 24 months old I had to go back to work and this prevented me from doing so... She liked it and she wanted it after that – especially in the evening and when she was upset”. She started walking when she was 12 months. Her first words around 18-20th month were “Mama”, “Tata”. Incontinence disappeared with time. No health problems are reported, apart from cold or similar ones, which have been cured in due time. Since her birth, she sleeps on her parents’ bed. Mother: “She used to cry at night and it was easier to keep her with us. The three of us still sleep on one bed. She is between us... this does not worry us”. She had been raised by her mother until she was 2 years old when she started going to the creche. Father: “She started crying when we approached the kindergarten. It was very hard for us too, but we did not have any choice. For some time my wife took sick leave. After around 2 months she stopped crying but she did not eat there... they told us that she did not speak or play with the children... she used to stay with us on the playgrounds and looked at them from the side. When we used to take her in the afternoons she was telling us what had happened and her “failure to speak” did not bother us.” At the age of 36 months, she was moved to a kindergarten. Mother “Everything was the same again... she cried, she did not want to eat... she did not speak to the children. Later we were told that she started to eat but things did not change with the speaking – they have not heard her voice for 3
years. Most people think this is so because she is very shy but one of the mothers of the children in her group asked me once if she had autism. We got very scared then, we talked to the GP and he calmed us... I sometimes think again about that... In the kindergarden, she liked one of the teachers and she was looking for her all the time but she did not start playing with the children”.

According to the parents, until her 3rd year, Mina did not demonstrate any specific differences from the other children. When walking in the streets, she did not separate from them and looked uncertain but at home and among the members of her extended family she has been calm and confident. Father: “She even commanded us and we joked that she was ready for a boss”. She wanted her parents to comply with her wishes more and more often and they regarded such type of behavior as positive - “she has leadership skills”. The fact that she did not communicate with other people they interpreted as a question of growing. They were more worried that she did not eat at the kindergarten.

The parents were taking the failure to speak as a sign of shyness but at the same time, they started feeling troubled about it. They could not visit their friends or go out because she did not talk, she was standing clung to the legs of her mother or father asking them to go home. Among the closer friends, she whispered in the mother’s ear. At the age of 6, she stopped talking to her grandparents. They did not understand how this happened and when it began. She continued to stay with them at certain days but she did not talk to them and when she wanted something she called her mother over the phone and she told them and when she learned to write, she just wrote them her wish. Father: “They started paying more and more attention to her because in order to understand her they had to look closely at her every reaction”. This coincided with manifestations of aggression. Mother: “She offended me over the phone when I told her that I cannot speak and when we were at home and I did not react immediately to her words, she sometimes hit me. She did that even more often towards her father. She still does it. She threatened us that she would not have dinner, etc. When I was upset with her behaviour, it did not bother her.” The parents saw their child was suffering and in order to calm her, just did anything she wanted them to do.

**From the diagnostic sessions**

Initially, Mina refused to enter the office; she pulled her mother in the waiting room, pushed and hit the father. The parents thought that the child was angry because just before that she wanted to go to a shop she loved. After a comment by the psychologist about the child’s disappointment with the changed plans and clarification of the objectives of the sessions, she gradually calmed down, grew quiet but remained clung to the mother. She showed that she followed the conversation and in case of disagreement with what has been said she hit the mother. She gradually started turning towards the specialist but did not establish eye contact with him.

During the second session which was on the next day, the girl was accompanied only by the father. At the beginning, she stood next to him, with her back turned towards the psychologist. She refused to sit on a separate chair. She did not answer questions, refused to draw or to play with the other offered stimuli. She watches the picture drawn by the specialist and the father with interest. At the end of the session a situation is simulated where Mina must hand down a pencil to the psychologist, which she did, but again she avoided eye contact.

Third session – Mina entered the office after her father. She tried to sit in him or move him away from the chair but finally, she accepted that she had to sit on her own. The picture from the previous session was presented and a suggestion was made for a new picture with the participation of all of them. She did not take part in it. She was assigned the task to hand down the colours her father and the psychologist needed. At the end of the session, she whispered drawing suggestions to her father.

Fourth session – entry into the psychologist’s office and taking seats not a problem. She accepted the offer that everyone should draw a character without the others watching. She drew geometrical figures under a template and filled in a labyrinth. There was no verbal communication but now there was eye contact, even though with limited frequency and duration. At this stage of assessment, after common discussion of the parents, it was suggested that the child should be included in a therapeutic programme, with the assessment of the child’s intellect and cognitive skills to follow soon. The parents insisted on continuation of the psychological assessment (Father: “It is useful for all of us, although you do not distinguish it from the therapy. Let us complete it in order to have a document that our daughter is smart”) and new meetings were appointed.

Fifth session – Mina accepts the offer to stay alone with the psychologist and to draw together. When asked to write her name on the new picture, she accepted and this enabled a dialogue in which the specialist asked a question verbally and the child answered in writing. She wrote predominantly with large print letters, relatively understandably, with few mistakes. In this way, in the next 5 sessions, the girl carried out a number of test assignments. She answered separate questions in writing or by whispering to the accompanying parent in the presence of the psychologist, but not directly. A large part of the time was dedicated to stimulation of communication and readiness for cooperation.
RESULTS

On the basis of intellectual abilities assessment, in comparison to the children at her age, currently, Mina demonstrates intellectual functioning within the wide limits at Full Scale IQ: $\text{FIQ} = 95$ under WISC-IV. The obtained results are relevant to the time of the study and can only be regarded as a source of hypotheses for the child’s development and condition. Her answers give reasons for the assumption of certain difficulties in revealing the meaning of frequently used words on the background of a relatively good basic understanding of them when presented in a notional context, as well as difficulties in the update of summarizing concepts and the skills for terminological conceptualization (Verbal Comprehension Index–VCI=87). Such specifics in the field of verbal understanding are revealed in written answers given by the child and are influenced by her abilities for written presentation. They are not equally manifested and are more likely to involve a possible specificity and not a generalized problem. The achievements of the assessment of the Perceptual Reasoning Index–PRI=96 are similar, where the results vary between 7 and 12, revealing peculiarities in the visual perception and organization. At this stage, Mina demonstrated an ability for compensation, based on the rendered support, her good memory and the organizational ability – Working Memory Index (WMI=100), Processing Speed Index (PSI=112).

Although she is able to answer only in writing or through her parents, it can be assumed that her abilities for verbal expression correspond to her age. This is confirmed by the video recordings provided by the parents, which reveal various situations of the everyday life of the child, family celebrations, holidays, etc., in some of which the girl speaks freely with her parents (but not in front of other people), using complex sentences, etc.

In Mina’s free drawings there are characters from topical animation and children’s feature films, depicted with their distinguishing elements and accessories. In a common drawing (B, D, P) - “Scrawl”, initially she took part with a reserve, but soon after that she started breaking the sequence and started getting ahead of her father, delete his elements, etc. This behavior does not apply to the psychologist, though. In a picture under instruction, the human figure is feminine, placed evenly on the medium part of the sheet, with the expected physical features, a smiling face, and standard clothes – according to the Koppitz’ evaluation system (Koppitz,1968; Koppitz, 1984), it corresponds to the actual age of the child.

For the purpose of provision of additional information about the girl’s behavior and her functioning in various social environments, the parents were asked to fill in the Strength and Difficulties Questionnaire (Goodman, 1997), as well as to cooperate for the filling in the variant for teachers available in the same tool. Their estimates show that Mina’s behavior at home and at school is very different, and in the family, the focus is both on the emotional and behavioral problems while at school the focus is on the emotional ones. On the other part, both parents and teachers assess the relationship with the peers as problematic and the prosocial behavior as very low. All those results reflect the behavior of the child herself and the point of view of the relevant informant, his/her experience with the particular child and with children in general, the specific requirements towards the child, etc.

Administration of the Autism Diagnostic Observation Schedule (ADOS-2) in order to exclude an underlying autistic spectrum disorder. ADOS-2 is a semi-structured, standardized measure for assessment of communication, social interaction, and play that has significant clinical utility in identifying children on the autistic spectrum and determining the severity of the disorder. Taking into consideration the expressive language level (“fluent speech”) and the chronological age of the child, Module 3 of the ADOS-2 was administered in accordance with the original guidelines. The sequence of 14 tasks was performed within one session. Initially, Mina reacted with reserve to the proposed activities but in the course of work, she demonstrated an increasing interest, sustainably engaging in the templates and maintaining reciprocal contact with the psychologist. The child brightened up emotionally in the performance of an imaginary and plot-role play („Make-Believe Play“, „Creating a Story“) – it develops relevant plots in a way typical for her age and involves appropriately the psychologist or any of the parents in the games. The verbal activity remains very low and compromises to a certain degree the presentation of tasks such as “Telling a Story from a Book”, „Conversations and Reporting“. The child told a short tale and answered certain questions whispering to the accompanying parent in the presence of the psychologist, but not directly. Analysis of ADOS-2 scores revealed an overall total score on Module 3 standard algorithm of 2 points, which is below the ADOS-2 autism cut-off and corresponds to “minimal to no evidence” of autism spectrum disorder. Clinical observations, along with other testing and information provided by teachers and parents support these findings.

DISCUSSION

The case presented by us may be determined as illustrating the specifics typical of the children with SM features, as well as the impediments that a psychologist is likely to face during the psychological assessment.

According to the good practices for psychological assessment, such discussion should enable the
manifestation of a child’s potential and not just the identification of the pertaining issues. To this end, a major step in the course of assessment is the provision of adaptation time for the purpose of ensuring the comfort of the child, achievement of cooperation and motivation for expression. In children with mutism, as in Mina, the time for adaptation is significantly extended. In most children with typical development and typical functioning especially at her age, the first minutes are usually enough for the psychologist to clarify his role, the purpose of the meeting and the events that would happen. The following interview supports the establishment of relationships based on trust between the specialist and the child and makes way for the actual psychological evaluation. In Mina this process spread over all 10 sessions and remained unfinished, persistently requiring the so necessary therapeutic aid. The question of whether the assessment should precede the therapy or follow it is reasonable. Based on the fact that the child’s silence limits the access to her knowledge and this presupposes serious distortion of the results, it is very natural to expect that the effect of the therapy would be reflected in a higher assessment result. This is confirmed by the registered dynamics in the child’s behavior in the course of the meetings. If a standard psychological assessment is realized within the context of 2 to 5 sessions, with opportunity for extension of the period of assessment, a more detailed insight into the child’s resource would be enabled.

The psychological assessment is a highly specialized professional activity including collection, scoring, and integration of information about a certain person using various methods and sources, according to previously set plan, for the purpose of an answer to a question of the client or his/her relatives. As indicated above, the choice of methods of assessment depends on the available professional standards on the one part and on the adopted models of work in the relevant institution, the specialist’s expertise and of course, the financial balance, on the other part. Most often both the specialists and the parents and also the children themselves connect the psychological assessment with the application of specific tests and/or questionnaires. Abiding by the rules of the Test committee at the European Federation of psychological associations, those tools should be standardized and adapted for the relevant country. In Bulgaria as at the time of studying Mina’s behavior and during the preparation of this paper, the officially used tools of psychological assessment are very few, for example, the only tool for assessment of the intellect of children and adolescents is WISC-IV and it started to be applied as late as 2015. In the psychological assessment described by us, the choice of methods of work was mostly governed by the child’s needs and abilities. According to the mod-
of certain emotional and physiological stress (Young, Bunnell, & Beidel, 2012). In the course of work with Mina, the discussion of speaking and failure to speak was the most difficult topic and therefore the access to information about the reasons, the occasion, the “cure”, etc., from the source was strongly limited. However, the change in her behavior in the course of the sessions, namely increase in her readiness to cooperate, the appearance of whisper which later turned into louder speaking with the mother/father (only separate words) in the presence of the psychologist gives us a reason to assume that the familiarization with the context and the presence of a specialist are of significant importance. Gradually Mina started spending more and more time alone with the psychologist.

In the cases of children with SM described in the literature, the manifestations of separation anxiety are often met. A number of authors describe a strong connection of dependency between the child and the mother and the mother herself is often described as over-protective and dominant (Hayden, 1980, Remschmidt et al., 2003). Mina’s mother defines herself as devoted to her child and her husband but during the sessions, the girl has been accompanied mostly by the father due to her “professional engagements”. Mina actively and intensely seeks physical closeness with her mother and is very attached to her, which makes it hard for her to connect with other people. The progress achieved in the previous sessions is lost in her absence and despite the verbally expressed desire of the mother for “separation” of Mina, she draws her closer to herself, which illustrates the need of subsequent work with the parents. This line of recommendations is also supported by the observed manifestations of difficult behavior and aggression, at this stage limited only to the mother and the father. Although the literature does not reveal specific data on aggressive behavior by children with SM, in our practice these are facts supported by direct observations, as well as by what is shared by the parents of such children. The possibility for observing the child and the parents in various situations, including on video, enabled us to outline the efficient and inefficient models in their interactions which in the following therapeutic sessions were developed and supported or replaced, respectively.

**CONCLUSION**

In conclusion, it could be summarized that the psychological assessment of the children with SM is a valuable source of information, a possibility for initial interventions and assessment of already conducted ones. It is worth noting that irrespective of the expectation that the early diagnosis would lead to faster and more valuable therapeutic results in children with such a diagnosis (and other diagnoses as well, since this is a major principle in early interventions), there are wide discussions of differentiation of certain personal traits, which are more clearly outlined in the period of adolescence and which could be hardly changed. If we believe that the children with selective mutism would become adolescents and adults and the need of intervention in due time is of great importance, this means that such interventions should be based not only on the child’s problem but also on its abilities and needs, which become accessible thanks to the psychological assessment.

**REFERENCES**

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders*, 5th. ed. Arlington, VA: American Psychiatric Publishing

Beidel, D. C., Turner, S. M., & Morris, T. L. (1995). A new inventory to assess childhood social anxiety and phobia: the social phobia and anxiety inventory for children. *Psychological Assessment*, 7, 73–79.

Bergman, R. L., Placentini, J., & J. T. McCracken (2002). Prevalence and description of selective mutism in a school-based sample. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41, 938-946.

Bergman, R. L., Keller, M. L., Placentini, J., & Bergman, A. J. (2008). The Development and Psychometric Properties of the Selective Mutism Questionnaire. *Journal of Clinical Child & Adolescent Psychology*, 37(2), 456-464.

Bergman R. L., (2012) *Treatment for Children with Selective Mutism: Appendix B: Pretreatment Materials.* N. Y. Oxford University Press.

Bronfenbrenner, U., & Morris, P. A. (2006). *The bioecological model of human development.* In W. Damon & R. M. Lerner (Eds.), *Handbook of Child Psychology, Vol 1: Theoretical models of human development* (6th ed., pp. 793 – 828). New York: Wiley.

Carbone, D., Schmidt, L. A., Cunningham, C. C., McHolm, A. E., Edson, S., St. Pierre, J., & Boyle, M. H. (2010). Behavioral and socio-emotional functioning in children with selective mutism: A comparison with anxious and typically developing children across multiple informants. *Journal of Abnormal Child Psychology*, 38, 1057-1067.

Dummit, E. S., Klein, R. G., Tancer, N. K., Asche, B., Martin, J. R. N., & Fairbanks, J. A. (1997). Systematic Assessment of 50 Children With Selective Mutism. *J. Am. Acad. Child Adolesc Psychiatry* 36(5) 653-660.

Elizur, Y., & R. Perednik (2003). Prevalence and Description of Selective Mutism in Immigrant and Native Families: A Controlled Study. *Journal of the American Academy of Child or Adolescent Psychiatry*, 42, 1451-1459.

Frigero, A., Rucci, P., Goodman, R., Ammaniti, M., Carlet, O., Cavolina, P. (…) Molteni, M. (2009) Prevalence and correlates of mental disorders among adolescents in Italy: the PSIWA study. *Eur Child Adolesc Psychiatry*, 18(4):217-26. doi: 10.1007/s00787-008-0720-x.

Goodman, R., Scott, S., & Rothenberger, A. (2007). *Kinderspsychiatrie kompakt* (2. Auflage). Darmstadt: Steinkopff.

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry*,
Hayden, T. L. (1980). The Classification of Elective Mutism. *J Am Acad Child Adolesc Psychiatry*, 19, 118-133.

Jacob Marini, L., Suveg, C., & Shaffer, A. (2013). Developmentally Sensitive Behavioral Treatment of a 4-Year-Old, Korean Girl with Selective Mutism. *Clinical Case Studies* 12(5): 335-347 DOI: 10.1177/1536465013492997

Kopp, S., & Gilberg, C. (1997). Selective mutism: A population-based study: A research note. *J Child Psychol Psychiatry*, 38(2), 257-262

Koppitz, E. M. (1968). *Psychological evaluation of children’s human figure drawings*. New York: Grune & Stratton.

Koppitz, E. M. (1984). *Psychological evaluation of human figure drawings by middle school pupils*. New York: Grune & Stratton.

Kristensen, H. (2001). Multiple informants report of emotional and behavioural problems in a nation-wide sample of selective mute children and controls. *European Child & Adolescent Psychiatry*, 38(2), 257-262

Lord, C., Rutter, M., DiLavore, P., Risi, S., Gotham, K., Bishop, S., Luyster R., Guthrie, W. (2012) *Autism Diagnostic Observation Schedule, Second Edition: ADOS-2*. WPS.

Lord C., & Rutter, M. (2003) *Autism Diagnostic Interview, Revised (ADI-R)* WPS.

Mental Health Foundation. (2007). *The Fundamental Facts*. Mental Health Foundation.

Remschmidt, H., Poller, M., Herpertz-Dahlmann, B., Henninghausen, K., & Gutenbrunner, C. (2001) A follow-up study of 45 patients with elective mutism. *European Archives of Psychiatry & Clinical Neuroscience* 251 (6):284-296.

Oerbeck B., Manassis, K., Overgaard, K. R., Kristensen, H. (2016) *Selective mutism*. In J.M. Rey (ed), IACAPAP e-Textbook of Child and Adolescent Mental Health. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions.

Schwartz, R. H., Freedy, A. S., & M. J. Sheridan (2006). Selective mutism: are primary care physicians missing the silence? *Clinical Pediatrics*, 45, 43-48

Shriver, M. D., Segool, N., & Gortmaker, V. (2011). Behavior observations for linking assessment to treatment for selective mutism. *Education and Treatment of Children*, 34, 389-410.

Silverman, W. K., & Albano, A. M. (1996). *Anxiety disorders interview schedule for DSM-IV: Parent interview schedule* (Vol. 3). New York: Oxford University Press.

Sourander, A., Helstela, L., Ristikari, T. Ikäheimo, K. Helenius, H., & Piha, J. (2001) Child and adolescent mental health service use in Finland. *Social Psychiatry Psychiatric Epidemiology* 36: 294. https://doi.org/10.1007/s00127-001-0047

Standart, S., & Le Couteur, A. (2003). The Quiet Child: A Literature Review of Selective Mutism. *Child and Adolescent Mental Health*, 8(4), 154-160.

Tick, N. T., van der Ende, J., Verhulst, F. C. (2008) Ten-year trends in self-reported emotional and behavioral problems of Dutch adolescents. *Soc Psychiatry Psychiatr Epidemiol*. 43(5):349-55. doi: 10.1007/s00127-008-0315-3

Wechsler, D. (2014). *Wechsler Intelligence scale for children-fifth edition*. Bloomington, MN: Pearson.

Wong, P. (2010). Selective Mutism: A review of etiology, comorbidities and treatment. *Psychiatry*, 7(3), 23-31.

Young, B., Bunnell, B., & Beidel, D. C. (2012). Evaluation of Children With Selective Mutism and Social Phobia. A Comparison of Psychological and Psychophysiological Arousal. *Behavior Modification*, 36(4), 525-544.