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Superhero Costumes as a Method for Treating Children with Selective Mutism: A Case Study

Nada Yousef Alrabiah

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Abstract

This chapter describes a creative method for treating children with selective mutism. It is a case study of a 5 year, 8 month old child who has been silent since the first day of school for 2.5 years. No one, for 2.5 years, has ever heard him speak. He used to stare at his classmates as they played but did not participate. His mother described his language as normal and behavior as quiet. When the researcher first saw him he was wearing a “Superman” costume. The researcher used the child’s ambition to be superman as a platform to think creatively to treat his deficiency. He spoke in 1 hour and 30 minutes. The single session treatment successfully treated the child and he was observed afterwards for 2 months, no relapses, and he continued speaking. To maintain the success, the teacher and the student-teacher were advised to use the “descriptive language approach.” He was observed regularly.

Keywords: selective, anxiety disorder, early intervention, treating using superheroes’ costumes, descriptive language approach

1. Introduction

Selective mutism (SM) is a condition of anxiety disorder most often diagnosed in children. According to the American Psychiatric Association (APA) [1], this condition occurs when a child persistently fails to speak in certain social situations where speaking is required, such as school, sport fields, church, restaurants, parks, or stores. It is a rare disorder affecting pre-school- and school-aged children [2]. Children with selective mutism are generally quiet in nature. The SM child chooses silence rather than a deal with the anxiety of the inability to speak in public, despite the child’s ability to speak normally at home. When the child encounters guests, relatives, or school populations, he or she turns to silence. The selective mute

children have no problem in language formation; they speak fine in their homes and around people they are comfortable with but their silence accelerates their language developmental delay. Some children who are shy or who have social phobia also have selective mutism. About 1% of children referred to mental health professionals are diagnosed with this disorder. This percentage equals between 0.03% and 0.02% of the general population of children. Selective mutism is a serious disorder which requires qualified professionals in mental illness [3, 4].

2. Symptoms of selective mutism

Despite the long history of deducting SM, the disorder is still not clearly understood, and much debate among mental health specialists continues regarding its appropriate classification and causes. Some of the major symptoms of selective mutism besides refusal to speak in specific situations are excessive shyness and anxiety, clinging behaviors to parents and safe significant others, fear of social embarrassment and social isolation, oppositional attitude, and negativity in evaluation. Children with SM often have delays in social skills as the result of limited experiences' exposure and limited opportunities to interact with peers socially and verbally [5, 6].

3. Etiology and elements of perpetuation of SM

Typically, this condition starts at the time of entering school for the first time. The onset of selective mutism is associated with the first separation of the anxious child from the primary caregiver. Early intervention, which constitutes early deduction and diagnosis, is mandatory in these cases [5]. According to the APA [1], before taking any treatment measures, symptoms must last for a month, excluding the first month of school enrollment, during which most children are shy. Although SM was originally thought to be a disorder of oppositional defiance, recent evidence has classified SM as a condition for both anxiety and avoidance disorder [7, 8]. This avoidance hinders new language learning and experiences. It was also possible that if anxiety is primary, speech and language deficits develop as selective mutism and it persists over time [9].

Some people are more apt than others to develop an anxiety disorder due to their "psychological vulnerability" which may interpret this condition [8, 10].

Selective mutism was referred to as "elective mutism." The negative connotation of this term, which implied the defiance and stubbornness that many teachers interpreted in the child's behavior, caused the APA to rename it selective mutism during the nineties.

Peers at school and social gatherings may make the selectively mute child self-conscious when he or she attempts to talk. The child becomes anxious upon initiating any attempt to vocalize because of the attention he/she attracts. Thus, the child may be dissuaded from repeating vocal attempts [5]. Naturally, the child feels uncomfortable being put on the spot; therefore, he or she will continue to prefer silence to dealing with anxiety. Another significant element of SM

causes is the acceptance, and sometimes favoring, of shy children in some cultures like some of the Middle East countries and Far East, which can make it difficult to identify the symptoms before the problem worsens.

Some studies suggest that a family history of shyness or anxiety may interfere with the social and emotional development of the child, but the theory of genetics as a cause of the syndrome remains unclear [11]. Traumatic events, poor reinforcement strategies, unresolved internal conflicts, and social and emotional family dysfunction are likely some of the causes of SM. These factors may inhibit the development of emotion regulation skills in children [6, 12, 13]. Oon [12] added that exposure to trauma and dysfunctional family relationships might trigger an existing disposition for SM. Researchers generally agree that anxiety disorder is a common cause of SM.

SM might be caused by a teacher reprimanding the child or seeing one of his or her peers reprimanded for a toilet accident or another reason [14]. Children of mobile families, such as immigrant families, are also at risk of developing SM greater than non-immigrant children.

4. Treatment choices

Behavioral therapy is among successful treatment with the options of behavioral techniques, such as contingency management, stimuli fading, systematic desensitization, and negative reinforcement shaping [12, 15]. One of the mostly used therapies for selective mutism is Cognitive Behavioral Therapy (CBT). CBT is an approach to problem solving. It is a tool for helping people to become aware of their irrational beliefs about themselves. This new awareness is a key to the client overcoming his or her problem. It works to modify the irrational beliefs and thoughts that cause maladaptive behavior by replacing them with more accurate, rational interpretations. Generally thoughts lead to our emotions and subsequent behavior. This approach is considered “behavioral” because it involves helpful behavioral techniques. CBT may be inadequate for small children in most of the situations [15].

Other method that may be convenient for younger children is Emotive Imagery, which was developed by Lazarus and Abramovitz [16]. They developed emotive imagery as a variant of systematic desensitization, which is an approach to the treatment of fear and anxiety problems in children [17–19]. Lazarus and Abramovitz [16] described emotive imagery as “imagery which is assumed to arouse feelings of self-assertion, pride, affection, mirth, and similar anxiety inhibiting responses” (p. 191). Through conversation, the therapist helps the child establish his or her imagination some superheroes or imaginary characters. Then the child is asked to close his or her eyes and imagine a sequence of events built around his or her “wish fulfillment” [16].

Using this therapy, Lazarus helped an 8-year-old girl who had nocturnal enuresis and a fear of going to school. Over four sessions, the therapist employed emotive imagery to assist the child in creating scenes and situations involving heroes she liked. By using this approach, the child managed to reduce her fear of going to school. She succeeded in overcoming her nocturnal enuresis in 2 months.

Roleplay as a technique in emotive imagery has an inherent healing power, which can help a child with SM to overcome the anxiety of speaking. Through roleplay, the child has the chance of experiencing a different side of him or herself. Through projecting aspects of him or herself, a selectively mute child can externalize inner conflicts in a metaphoric manner to obtain a new perspective. These roles can provide “the stepping stone from which the child may gain the confidence to speak as others before speaking directly as herself” ([12], p. 219).

Play therapy as a treatment approach is well established and widely favored. The popularity of play as a therapy increased with the work of Virginia Axline (1950). It is a self-guided process where clients express their feelings and challenge their irrational beliefs in the play room communicating through toys. Generally play therapy employed with children aged 3 through 11. Nowadays it is used with adults too.

5. Current case study

5.1. History and referral

A student teacher (Tahani) invited the researcher as a researcher/therapist to the kindergarten where she had practicum in order to help her with a male child. The subsequent information and characteristics she provided the researcher with were usually manifested on the selective mutism child. The boy, Fahd (a pseudonym), had not spoken for 2.5 years since he was enrolled at age three in preschool. At the time of therapy, he was 5 year, 8 months. He was the youngest of the three siblings. According to Tahani, teachers and kindergarten staff, Fahd was shy and quiet. His mother told his teachers that Fahd was quiet in the house too. School special education specialist reported that his hearing ability was tested, with positive results. She had seen Fahd and tried to help him speak. At school his teachers considered him “stubborn, never cooperated with teachers.” He was a big boy in stature compared to his peers. His previous teachers described to Tahani his difficulty in separating from his mother when he first enrolled in preschool 2 years previously. He avoided social situations, and he was silent in the classroom and in performance situations.

The family of this child had limited resources. They were unable to take him to a specialist; therefore, the child continued showing symptoms of selective mutism for more than 2 years. I was the researcher and the therapist she felt helpless and she approached the researcher at her university, asking for help. The researcher had experience working with maladaptive behaviors like SM, and in using CBT and play therapy (PT). The researcher/therapist visited the school site school in the fall of 2011.

5.2. Treatment trajectory

That morning, the researcher/therapist entered the kindergarten with a tentative plan to meet the child, start a relationship, and prepare him for play therapy, which she thought appropriate for his age. PT was an approach that she believed in. Nevertheless, each case

dynamics and elements constitutes the appropriate therapy to start with. In this case, Fahd “initiated his treatment” when he decided in the first day of therapy to wear a Superman costume to kindergarten.

To the researcher/therapist’s surprise, when Tahani pointed at the child, she saw a quiet, lonely child wearing a Superman costume. Based on previous experiences with superheroes costumes, she assumed that the child might be silently calling for help, after living for 2.5 years in silence. The researcher/therapist changed her plan to accommodate the child’s passion for superman costume which might help the child in the desensitization process of his anxiety of public speaking. There was no Internet access at the school; therefore, the researcher/therapist drew a picture of superman. She decided to start the therapy by using fiction around the superhero. The researcher/therapist’s goal was to help Fahd speak while he was under desensitization created by unspoken ownership of the costume he was wearing. Being in a superman costume, the child felt responsible about it. If a scenario created and required someone to speak for superman, the unspoken ownership might desensitize him and lead him to vocalize or speak in best case scenario (**Figure 1**).



Figure 1. Picture drawn by the researcher.

5.3. The sequence of the session

- **Superman picture:** Drawn by the researcher/therapist to be used for the fictional story, and as an acknowledgment of Fahd's passion for the superhero. It was an image he might inadvertently relate to.
- **The script:** The researcher/therapist wrote a script for a fictional story tailored for Fahd, related his fantasy of wearing superman costume. The story started with a "pleasant setting which evoke[d] positive emotions" [17] and was about a girl driving a beautiful car over a bridge, and then suddenly driving over a fence and hanging suspended from the bridge: a "sudden negative event" [17]. In the story, a TV reporter was driving by and announced the news of the accident from his car. Police called her parents and people gathered. Her parents arrived but could not help her. At that moment, Superman flew in and saved her and her car. This scene was accompanied with positive initiatives as superheroes. The purpose of evoking emotions is to inhibit the anxiety [17].
- **Setting the stage:** The setting for the story and role play was in the library which was equipped with the story probes from school materials, blocks for the bridge, a microphone for the TV reporter and a big toy car.
- **Story time:** The Tahani shared with her class (12 children that day, including Fahd) that they were going to the library to enjoy listening to a new story.
- **Drama time:** After the story, the Tahani gave the children the choice to play the roles they liked. To minimize stress on Fahd for public expectancy of him to play the role of Superman.
- **No strangers:** The researcher/therapist decided not to join the class. She was listening to the chain of events through the library door, which was left ajar.

The procedure went better than planned. The Tahani told the story dramatically and vigorously. When she asked the children if someone is interested to play the roles of the driving girl, the TV reporter, and the parents, some children showed interest and took the roles. The minute the student teacher Tahani said, "Who will play the role of Superman?", a loud shriek, "I will play Superman, see I am wearing Superman, look at me I am wearing Superman, I am Superman." The researcher/therapist's visit lasted for less than 2 hours, she arrived at the school at 8:00, and Fahd spoke his first words at 9:30. She left the school without even having made eye contact with the Fahd. The main class teacher was absent that day, so the researcher/therapist explained the maintenance measures to the Tahani. The maintenance measures, listed below, were crucial components of the treatment.

5.4. Maintenance measures

Observation: Tahani was instructed to write daily observations about the behavior and progress for a week.

Reinforcement technique: Later class teacher and Tahani were instructed to use the descriptive language approach (DLA) [20] with Fahd throughout the day, every day. This is a powerful

reinforcement technique upon which early childhood teachers depend on to encourage children. This technique applies to all typical children and adults not just children with disorders. It involves describing to the child in details what he/she does without any judgment, in order to help him/her pay attention to his accomplishments, rather than concentrate on pleasing adults, parents, or teachers. For example with little children, "I see you drew three circles on the left side of the paper and a red box underneath," instead of "Oh beautiful drawing, I loved it." Another example with older kids "you knew the bike's tires needed air, you checked the valve type, bought a pump and inflated them) instead of "Great you did it, you are smart, I am proud of you." Gradually, besides acquiring more vocabulary and improving language, the child develops pride in his or her work, and self-worth increases accordingly. This approach is appropriate for use with a targeted child among siblings and peers, because no one will feel jealous if an adult uses it as a form of encouragement, as opposed to conventional praise ("Oh that is a great picture"). This approach is realistic and not faked. It focuses on confidence-building. Teachers reported less relapses with this reinforcement approach when the researcher/therapist advised utilizing DLA as a maintenance tool with the cases she had treated. When the targeted children are feeling confident and content, relapses in therapy are minimized. DLA has additional advantages, which will not be discussed in another future research.

Student teacher observation notes: On the day of the successful therapy, she wrote, "During outside playtime Fahd was shouting, 'I am the courageous Superman. Call me if anyone needs my help'" (repeatedly). Next day he was talking normally to his peers. He started making relationships and requesting to play with peers ('Ahmed, I want to play with the block with you'). Fahd did not wear the Superman costume the next day, and he never did later. Tahani and the class teachers continued to monitor him for the next 8 weeks, and the intervention gains were sustained.

6. Discussion

6.1. Why the superhero costume?

In the above case, the Superman costume may help the child develop positive skills. The costume was "the response induction aid." In the case study of Jackson and King [18], a 5.5-year-old child who was referred to him for fear of dark, noises and shadow. He described how the treatment of emotive Imagery and the use of the "torch" enhanced the child's positive coping skills too. He named the use of the torch "the response induction aid." To the researcher humble knowledge, there is hardly any references any references about using superhero's costumes. Many resources studied Superheroes but not Superheroes' costumes. Therefore, the researcher/therapist recalls two unsearched cases when she was working in a kindergarten prior to her recent work at the university. The first one was a very shy boy 6 years of age. The only variant that took place in relation to his shyness condition was a costume of a Power Ranger which his mother bought. Whenever he wore it in the kindergarten he acted happily and confidently. According to his mother and teachers, few weeks later and with no professional help he showed confident behaviors without even wearing the costume.

When wearing a costume, children tried out different roles and lived them later in real life. Children identify superheroes in accordance with their own needs. A girl who was small in built and was always abandoned by her friends identified with Tasmanian devil (Taz). According to her teachers and mother, she mostly drew the pictures of Taz at home and school. For her Taz might be huge, voracious but kind. Through watching Taz videos, she managed to win over her peers with her kindness and support, as she saw these traits in Taz, despite his ugly appearance.

In the current case the shriek of the child was not a protest against someone else trying to take the role; rather, it was a protest against the fears and silence that hindered him from being what he wanted to be throughout the last 2.5 years. Fahd might have wanted to be courageous self-confident and heard. It was a dramatic moment, over which Tahani and the researcher/therapist both wept. The approach was a convenience treatment evolved from the fallout of the case long term and its dynamics. The researcher/therapist had planned to meet the child and talked to him, but the superhero costume invited a creative way to address his condition.

6.2. Suggested procedures for utilizing superhero costume therapy

Superhero introduction: The therapist, teacher, and parents should work together to casually introduce a few superheroes with characteristics that may speak to, or complement, the child's limitation.

Superhero connection: The best ways to connect to a character are through reading stories and watching movies.

Superhero costume: When the child dresses in the superhero's costume, he or she may act out the character's role at home or school.

Treatment selection: The treatment will depend on the child, the problem or disorder, the researcher/therapist's experience.

This case study suggests that the therapist can get the lead of the trajectory of their treatment from the children's cues. Fahd had reached a state of inhibition caused by this anxiety. The superhero costume might be an opportunity to save him from despair. As a therapist, I assume Fahd seemed to master his fear and anxiety through the costume which provided him a mask of his sense of vulnerability. Tahani reported that the day he spoke was the third time he'd worn it since she had been his student-teacher.

The Superman story was the metaphorical ladder that Fahd climbed, to cry out loud "I am the courageous Superman." All that was needed was a script. The costume created a systemic desensitization. The researcher/therapist had always believed in superheroes' power in influencing the souls of children. She used to encourage the mothers of shy children to purchase superhero costumes. Costumes are not favored in all societies, as they do not represent all cultures and are considered unsafe when the child imitates the character's behavior. Many people find it difficult to believe that they can have a strong influence on a child's psychological state.

The approach used in this case study can be described as a psychodynamic. It assumes that a maladaptive behavior is due to an internal conflict, and that clients can gain insight through

art, play, or drama [5]. Exposure principles are established through the indulgence to drama events. In this case study, Fahd was ready, and tired of living in silence; his first words may support this argument. The treatment components for this approach are the child's emotional state, the costume, the story, and the tailored script.

This novel intervention is the first of its kind, and it is not well established or studied. I encourage researchers to study its potential, as well as its limitations, more methodically. Superhero costumes can be considered a variant of systematic desensitization for the treatment of selective mutism. This suggested therapy might be a type of emotive imagery [16] with a twist. Lazarus and Abramovitz [16] developed emotive imagery as a variant of systematic desensitization. It is an approach for treating fear and anxiety problems in children. The difference between emotive imagery and superhero costume therapy is presented in **Figure 2**. They are assumptions and need to be studied thoroughly.

Emotive imagery	Superhero costume therapy
<ul style="list-style-type: none"> • The therapist leads the imagining of a hero and imagining of the child as the hero's "agent" as used by Lazarus and Abramovitz • • Directive • Session occurs mostly in therapy room • • The child might be more self-conscious • Safe therapy • Requires skillful therapist • Some children might resist • The therapist must be prepared with a repertoire of questions 	<ul style="list-style-type: none"> •The child imagines himself or herself the hero while wearing the costume •Less directive •Intervention possible <i>in vivo</i> •The child is less self-conscious •The child might hurt himself or herself imitating superheroes •Teachers in remote areas might be able to help children with SM •Less chance of intervention resistance •No direct questions during the session

Figure 2. Comparison between emotive imagery and superhero costume therapy.

7. Recommendations

Sometimes the child will declare his treatment, like Fahd did. Therefore, therapists must pay attention to cues and study them from different perspectives and use all the available resources of information such as teachers, family, and peers. Family involvement is usually crucial, but in this case the family played small role before starting the treatment. As a therapist, she should have worked from a "family-system perspective and focused on changing any unhelpful family dynamics" that may have perpetuated the mute behavior [12]. Initially, the researcher is

saying that as a disclaimer because she visited the kindergarten to help a SM child with no plan to publish the experience.

Generally, the therapist can utilize more than one approach for treatment for children with SM. The child's moods and surroundings differ from one day to another. Family dynamics and school events will help determine the model a therapist must adopt.

A maintenance technique like DLA is highly recommended. Tahani's successful application of the steps of treatment created by the researcher/therapist, as well as the maintenance techniques she mastered and practiced daily with the child (which prevented relapses), was appreciated by the researcher/therapist.

This case emphasizes the exceptional potential of utilizing superheroes costumes as a medium for therapy. Children can hide their fear and vulnerability behind these costumes. Superheroes facilitate the exploration of qualities, values, limitations, self, and family [21]. Rubin [21] published a book about Superheroes. Hopefully in the near future we can have a book devoted solely to Superheroes' costumes.

To the author's knowledge, there are no records in the literature of utilizing superhero costumes for SM therapy. Some books spoke about using superhero toys and figures in therapy.

8. Limitations

This procedure might be limited to children who have a fascination with superheroes. Extra effort from parents and teachers may help children build interest in superheroes. Different superheroes characters are associated with different traits. Another limitation is that superhero costumes may jeopardize the child's safety depending on the character's representation and the child. The costumes should be utilized with caution.

Regardless of its limitations, superhero costume therapy has potential as a type of emotive imagery, and offers a zone of social and emotional development that might be helpful in the therapeutic treatment of selective mutism and other maladaptive behaviors.

The researcher/therapist is an early childhood majored with a counseling background in Master. Play therapy was her favorite course in graduate program. This was the second case in which metaphor and roleplay were used. Both cases were treated in a short period of time—less than 3 days—and relapses did not occur.

Author details

Nada Yousef Alrabiah

Address all correspondence to: nalrabiah@ksu.edu.sa

King Saud University, Riyadh, Saudi Arabia

References

- [1] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: American Psychiatric Association; 2013
- [2] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Washington, DC: American Psychiatric Association; 1994
- [3] Cunningham CE, McHolm AE, Boyle MH. Social phobia, anxiety, oppositional behavior, social skills, and self-concept in children with specific selective mutism, generalized selective mutism, and community controls. *European Child & Adolescent Psychiatry Journal*. 2006;**15**:245-255
- [4] Kearney CA. *Silence Is Not Golden: Strategies for Helping the Shy Child*. New York: Oxford University Press; 2011
- [5] Hung S, Spencer MS, Dronamraju R. Selective mutism: Practice and intervention strategies for children. *Children & Schools*. 2012;**34**(4):222-230
- [6] Scott S, Beidel DC. Selective mutism: An update and suggestions for future research. *Current Psychiatry Reports*. 2011;**13**:251-257
- [7] Bork PM. Overcoming selective mutism: Play now...talk later! In: Paper Presented at the Designing for Children Conference, Mumbai, India; 2010, February
- [8] Reuther E, Davis III T, Moree B, Matson J. Treating selective mutism using modular CBT for child anxiety: A case study. *Journal of Clinical Child & Adolescent Psychology*. 2011;**40**(1):156-163. Available from: Ipswich, MA: Academic Search Premier [Accessed 23 March 2017]
- [9] Tannock R, Martinez Y, Manassis K, Garland E, Clark S, McInnes A. The teachers' role in the assessment of selective mutism and anxiety disorders. *Canadian Journal of School Psychology*. 2015;**30**(2):83-101
- [10] Viana GA, Beidel DC, Rabian B. Selective mutism: A review and integration of the last 15 years. *Clinical Psychology Review*. 2009;**29**:57-67
- [11] Kristensen H, Torgersen S. A case-control study of EAS child and parental temperaments in selectively mute children with and without a co-morbid communication disorder. *Nordic Journal of Psychiatry*. 2002;**56**(5):347-353
- [12] Oon PP. Playing with Gladys: A case study integrating drama therapy with behavioural interventions for the treatment of selective mutism. *Clinical Child Psychology and Psychiatry*. 2010;**15**:215-230
- [13] Therese K, Fernandez G, Sugay CO. Psychodynamic play therapy: A case of selective mutism. *International Journal of Play Therapy*. 2016;**25**(4):203-209
- [14] Shott EF, Warren ME. Selective mutism: Treating the silent child. *Zero to Three Journal*. 2011;**31**(6):15-19

- [15] Bergman RL. Treatment for Children with Selective Mutism: An Integrative Behavioral Approach. New York: Oxford University Press; 2013
- [16] Lazarus A, Abramovitz A. The use of "emotive imagery" in the treatment of children's phobias. *Journal of Mental Science*. 1962;**108**:191-195
- [17] Cornwall E, Spence S, Schotte D. The effectiveness of emotive imagery in the treatment of darkness phobia in children. *Behavior Change*. 1996;**13**(4):223-229
- [18] Jackson H, King NJ. The emotive imagery treatment of a child's trauma-induced phobia. *Journal of Behavior Therapy and Experimental Psychiatry*. 1981;**12**(4):325-328
- [19] King NJ, Heyne D, Gullone E, Molloy GN. Usefulness of emotive imagery in the treatment of childhood phobias: Clinical guidelines, case examples and issues. *Counseling Psychology Quarterly*. 2001;**14**:95-101
- [20] Faber A, Mazlish E. How to Talk so Kids Will Listen & Listen so Kids Will Talk. New York: Scribner; 1980
- [21] Rubin LC. Using Superheroes in Counseling and Play Therapy. New York: Springer; 2007