REACH Journal of Special Needs Education in Ireland, Vol. 20.1 (2006), 45-54

Including a Child who is Selectively Mute in a Primary Classroom

Knowledge, empathy and careful planning are essential factors in successful intervention with children with selective mutism. This case study outlines some of the important steps involved in helping a young child to communicate with his teacher and peers in a mainstream classroom.

PAULA HENRY is a primary school teacher in the Dublin area. MICHAEL SHEVLIN is a lecturer in special education in the Education Department, Trinity College Dublin.

INTRODUCTION

Children who experience selective mutism encounter serious difficulties in social interaction and participation in the learning process in schools. Selective mutism is a rare but complex childhood anxiety disorder characterised by a child's inability to speak in select social settings, such as school or other place where there is an expectation for speaking. These children are able to talk normally in settings where they are comfortable, secure and relaxed. Within the classroom setting teachers are usually baffled by the phenomenon of selective mutism in a child as they may have limited experience and knowledge of this condition and the consequent implications for classroom practice. Research on selective mutism internationally is limited and few studies address the social and academic implications for the child involved, for his/her peer group and the teacher within the classroom environment. Within this paper the authors will attempt to remedy this imbalance through examining the experiences of a teacher working over the school year with a child who is selectively mute.

BACKGROUND

The defining feature of selective mutism is the consistent failure of the child to speak in particular social settings though they may speak in other situations. Children with selective mutism speak freely to only a small number of people with whom they feel comfortable. Usually therefore, they speak to their immediate family members at home and have most difficulty at school, this being perceived as a strange environment full of unknown people. Since the selective mutism may not impact on the child's life outside school, parents may lack awareness of the degree and effect of the mutism on the child's life in school (O'Neill, 2005).

According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association, 1994), the condition can be diagnosed if the selective mutism has a duration of one month not limited to the first month in school. However, others (Cline and Baldwin, 1994) state that six months or two school terms is more appropriate in order to eliminate those who may be shy, slow to warm up, reluctant to talk for other reasons, or whose mutism will resolve spontaneously within this period.

Diagnosis is not always clear-cut as in the past this condition has been confused with autism, defiant behaviour and even classified as a mental disorder. The most commonly agreed upon figure for the prevalence of selective mutism is about one in 1,000 children (www.selectivemutism.org). However, as Johnson and Wintgens (2001) point out there is a real risk of under-identification as children with selective mutism tend to be inconspicuous and adopt a low profile within the classroom and may never be referred for psychological assessment. Variations in prevalence reports could also be due to several factors as documented by Cline and Baldwin (1994) including the age of the children, the breadth of criteria employed and the location of the children in the study.

Generally, speech and language difficulties are more common in boys than girls; however, selective mutism appears to be an exception to this trend. Cline and Baldwin (1994) and Lebrun (1990) concluded that selective mutism affects girls more frequently than boys. No convincing arguments have been advanced to explain this difference though Cline and Baldwin (1994) believe that cultural influences are an important factor without discounting a possible genetic link. Diagnosis of selective mutism generally occurs between the ages of five and seven years though there is some evidence that onset of the condition could develop much earlier in the child's life (www.selectivemutism.org) and is belatedly recognised when the child enters school. The exact cause of selective mutism remains undetermined though there is consensus that anxiety is commonly associated with this condition. Originally, it was believed that this condition arose as a result of a major personal trauma though this explanation has been discounted in the majority of cases. Current research suggests that selective mutism is a component of a personality profile consistent with shy and withdrawn behaviours that is expressed as mutism within the social context of speaking (Johnson and Wintgens, 2001). Johnson and Wintgens outline predisposing, precipitating and perpetuating factors involved in the development of selective mutism. Predisposing factors include:

- the presence of a speech and language impairment in the child;
- anxiety within the child;
- geographical or social isolation;
- family history of shyness or selective mutism or other psychiatric illness, especially anxiety.

The precipitating factors include loss, death, divorce, frequent moves, self-awareness of speech impairment, teasing and other negative reactions. With regard to the perpetuating factors, there are many anecdotal examples of reinforcement received by selectively mute children that is counterproductive to the elimination of their mutism. Extra attention and affection (positive reinforcement) may be given inadvertently to the child who does not speak out, by a range of people at school and home. Negative reinforcement is also evident in the relief a child finds in not having to talk where silence develops far more pleasurable associations than speaking.

Selective mutism in a child may provoke negative teacher reaction (Cline and Baldwin, 1994) as teachers may feel threatened and attribute it to pupil defiance. This reaction may be partially explained by the low incidence of selective mutism and consequent limited teacher experience of coping with this condition. In addition, as learning through language

is central to the curriculum, the teacher may be frustrated in the effort to provide meaningful learning opportunities for the child and as a result feel professionally inadequate.

STRATEGIES

Treatment programmes have varied depending on the preferred aetiology of selective mutism. Learning theorists emphasise the interaction between the child and his/her environment and view selective mutism as a learned pattern of behaviour. This refusal to speak is interpreted as an attempt by the child to manipulate the environment to make it more acceptable and comfortable (Baldwin and Cline, 1994). Although there is no one specific approach, behavioural methods appear to be the most frequently recommended. Behaviour therapy is based on the premise that the child who is selectively mute is using the behaviour in response to anxiety in social situations or to gain attention (Pionek-Stone, Kratochwill, Sladezcek and Serlin, 2002). The focus of the therapy is to reinforce speaking, or anything that approximates speaking, and not to reinforce the mute behaviour. This may be done through 'stimulus fading', in which the speech-language therapist sets simple goals and gradually increases expectations until speech is achieved (www.asha.org/speech/disabilities/Selective-Mutism.cfm).

It is also recommended that parents emphasise their child's positive attributes and encourage socialisation and help them to become more comfortable in social situations. This approach aims to reduce the child's anxiety in social situations and to enable the child to gain in self-confidence and self-esteem. Speech-language therapists may also work with specific speech and language problems that are making the mute behaviour more intractable. Some children are afraid to speak because they do not like the sound of their voice and in this situation the speech-language therapist will work on speech pronunciation to increase the child's confidence and clarity of speech. This approach seems to work best in children who are relatively young and whose speech is causing them to feel particularly self-conscious.

METHODOLOGY

It was decided to adopt a case study approach (Bassey, 1999) in order to document over the school year the teaching strategies employed and the responses of the child (James – a pseudonym) who has selective mutism:

- throughout the course of the year, observations of James in different social settings by the class teacher, the learning support teacher and other teachers, for example, those on yard duty, were used to create an up to date profile;
- journal keeping of key moments, observations, intervention strategies and their outcomes kept by class teacher;
- communication with James and interviews with James constituted the methodologies employed in this study.

Permission was sought from James's parents to conduct this type of case study based on the clear understanding that the main purpose was to enable James to become an active

participant in classroom activities. One of the authors of this paper was directly involved in this study and will be referred to as the teacher (classroom) throughout.

CASE STUDY

This case study was conducted in a number of phases over the school year including initial observations, consultation with parents, researching intervention strategies, implementing agreed interventions and continued observation of impact on and response from James. Due to the protracted nature of the case study it is only feasible to present critical incidents and observations.

Initial Observations

James – the focus of this study – is seven years of age, the youngest in his family with an older sister aged twelve and an older brother aged fourteen in a post-primary school. James attends an urban school and is in first class that contains eighteen children (seven girls/eleven boys). Four children in the class have been identified as having special educational needs. James displays strengths in mathematics, art and physical education though has some difficulties in reading and phonics. By the time he reached first class James had spent four years in this school having attended the Early Start project that aimed to provide optimum learning conditions for young children from socially and economically disadvantaged backgrounds. James had not spoken at all in the presence of school staff. He used a series of gestures to indicate his wishes such as tapping the teacher on the shoulder and pointing to the toilet. When asked a question in class James would mouth the answer without any sound or hold up the appropriate number of fingers in response to a mathematics question. His classmates often commented that "James doesn't speak, he never has".

While appearing reasonably comfortable in the classroom environment, it was noted that James reacted aggressively to other children at break-time. This behaviour combined with the selective mutism prompted school action and James's parents were called in to discuss the situation. From this meeting it became evident that James spoke freely at home and the selective mutism and aggressive behaviour were confined to the school environment. Parents and school staff agreed that intervention strategies should be developed to address the situation. The classroom teacher undertook the task of researching and implementing intervention strategies with the agreement of James's parents.

Strategies for Intervention

Guidelines for intervention strategies were developed from reading the relevant literature and these formed the basis for communication and interaction with James through the school year. Johnson and Wintgens (2001) identified key issues in relation to devising an intervention framework:

* establishing rapport between the teacher and the child;
* enabling the child to become an active partner in the process;
* gradually eliciting speech;
* attempting over a period of time to ensure that the child can generalise speech in a variety of school settings;

* phasing out of teacher support as child gains confidence.

Establishing a 'safe' environment for the child constituted a key priority and teacher expressions of warmth, support and encouragement can contribute significantly towards achieving this aim. The child's anxiety hierarchy needed to be identified and speech elicited in those places where the child felt most comfortable. Non-verbal activities are recommended such as board games with adults. Initially the teacher should accept non-verbal attempts at communication though gradually increase the expectations for verbal communication and phase out responses to non-verbal interactions. Vocal responses may also be shaped as described by Brown (www.acposb.on.ca/mutism.html):

1 child mouths the word 'book'
1 child whispers the word 'book'
1 child whispers 'I need a spelling book'
1 child whispers the whole sentence but says the word 'book' aloud
1 child can say the whole sentence aloud.

This sequencing would occur initially with just teacher and child and could be gradually extended to include classmates. Interim strategies could include:

- encourage the child to speak to the teacher and his peer group from behind a closed door or screen;
- allow the child to audio or videotape him/her self at home and play recording to class with child and parental permission;
- employ hand puppets when the child remains out of sight;
- enlist an older child as a 'reading buddy';
- reinforce approximations to speak, such as whispering, though the teacher must be cautious and not over exuberant in praising any attempts at vocalisation as this may increase the child's anxiety and discourage further interaction;
- avoid any form of coercion, punishment or bribery as these are usually counterproductive;
- do not insist on eye-contact during interaction with the child.

Implementing Intervention Strategies

This can be documented under the five intervention strategies as suggested by Johnson and Wintgens (2001). However, these do not happen in isolation; rather, they consistently overlap.

1. ***Establishing rapport between the teacher and child***

Establishing a 'safe' environment constituted the first priority. The teacher reassured James that he would not be forced to do anything that caused him anxiety, opportunities for regular feedback would be provided and any intervention he deemed inappropriate would be immediately ended.

2. ***Enabling the child to become an active partner in the process***

Initially, James was asked to tape record his own voice within the comfortable environment of his own home. James appeared delighted with this suggestion though he was unwilling at this stage to allow his classmates to listen to the recording. After this initial stage James

appeared more willing to participate in group activities within the class environment and volunteered an answer to a mathematics problem. This answer consisted of a very low whisper and represented progress that continued over a number of weeks. During feedback sessions with James the teacher ascertained that he was quite willing to communicate with her about the situation. James was still reluctant to talk openly within class and the following exchange took place:

Teacher: "Are you ready to use your real voice now, the nice voice that you recorded on tape"?
James: "No, not yet. I have to put the picture of me using it in my head first. Then I will be able if it is a nice picture".

James was involved in the Christmas play presented by the class and had a speaking part involving one sentence said together with another child. James appeared very excited about the play but refused to say his line within the classroom though he reassured the teacher that he would participate fully when the play was presented. However, though dressed for the part, James felt unable to deliver the line.

3. ***Gradually eliciting speech***

After Christmas James began to communicate with his classmates using a deep husky voice (not his real voice) and appeared to be delighted with this development. The teacher took this opportunity to ascertain if James was ready for the class to hear the tape recording of his voice. James agreed to this and after checking with him on a number of occasions the teacher played the tape for the class. James had decided he wanted to be present during this session. The response of the other children to the tape recording was quite muted though some comments included:

"He sang that a bit fast didn't he"?/ "That was nice". However, James was not prepared to use his real voice though he felt very positively about the whole experience:

"Playing the tape helped me to imagine the picture in my head of me using my real voice more real".

4. ***Attempting over a period of time to ensure that the child can generalise speech in a variety of school settings***

At this stage James encountered great difficulty in trying to explain why he felt unable to use his real voice in class. In order to develop communication around this issue and given his proficiency in art the teacher decided to ask James to try to draw his voice. Using his drawings James was able to describe what prevented him from talking:

"It is something inside of me, in my blood that becomes bigger and bigger…when I put on my school uniform I just freeze and feel shy. The pink stuff (representing the block inside him) *would get bigger and I wouldn't be able to use my real voice".*

On the school trip, almost inadvertently, James began to speak to his friend using his real

voice though when this was commented on by his classmates he discontinued. On a few occasions during the trip he used his real voice though on returning to the classroom he reverted to his husky voice. During feedback with the teacher, James observed that "*the pink stuff is getting smaller".*

5. ***Phasing out of teacher support as child gains confidence***

On the final day in school before the summer holidays James stayed behind and told the teacher: *"I wanted to use my real voice in school today. I wanted you to hear it"* but despite this wish he remained unable to use his real voice. However, a little later the teacher received a phone call from James's mother recounting his disappointment at being unable to use his real voice and then James took the telephone and said *"Goodbye"* in his normal voice. Both mother and teacher reinforced this action through appropriate praise.

DISCUSSION

This case study illustrates some critical issues for schools in working with children who experience selective mutism. These issues include the personality profile of the child and the design and implementation of effective intervention strategies.

James appeared to fit the personality profile of the selectively mute child as outlined by Cline and Baldwin (1994). He was withdrawn and experienced severe anxiety in routine classroom interactions. These traits were particularly evident as James attempted to progress to the next stage from silence to whispering, from whispering to an approximation of his voice and finally to his real voice. Within this context, establishing a trusting relationship with the child was central and involving the child in decision-making around talking/interacting was essential for the growth of self-confidence and enabling the child to progress at a comfortable pace (Johnston and Wintgens, 2001). Despite the teacher's lack of experience in working with children who have selective mutism there was considerable evidence of an encouraging, patient approach that helped to facilitate the child's progress.

The intervention strategies appeared to be very effective in enabling James to make substantial progress over the school year. Successive approximations (O'Neill, 2005) were evident as James progressed from non-speaking to whispering to using a voice and the teacher consistently reinforced this behaviour. Further, the teacher allowed James to dictate the rate of progress and regular feedback sessions enabled James to feel in charge of the process as any attempt at forcing him to speak would be counterproductive. Phasing out teacher responses to non-verbal communication and gradually increasing the expectation for verbal communication, as recommended (www.acposb.on.ca), proved to be an effective strategy. This increased expectation for verbal communication was reinforced through the use of tape recording and drawings. Through the tape recording James was encouraged to use his real voice within his home and this provided a vital link to his peer group who recognised that James could speak. The drawings produced by James appeared to give him the opportunity to visualise and 'name' his difficulty and recognise the progress he had made during the year.

The five phases of intervention (Johnson and Wintgens, 2001) discussed earlier provide a

useful measure for assessing the progress of the child. It was apparent that the teacher had managed to establish a positive rapport with James based on a non-threatening approach that encouraged various forms of non-verbal participation in classroom activities. James became an active partner in the process through his involvement in tape recording, drawing and articulating, to a certain extent, his difficulties with speech within the classroom context. Speech was elicited gradually as approximations to speech were accepted and reinforced by the teacher. However, it was evident that by the end of the school year, though considerable progress was made, James had not reached the stage of generalising speech to unfamiliar situations within the school context. It was also apparent that James required ongoing support to ensure curricular access and social interaction.

CONCLUDING COMMENT

Selective mutism, though rare, can seriously disrupt a child's participation in curricular and social activities within school. Lack of knowledge about this condition among teachers can have a very negative impact on the opportunities available to the child to make both social and curricular progress. Informed and sensitive interventions have the potential to enable the child to overcome his/her difficulties and begin to establish meaningful relationships with adults and peers within the school setting. Creating responsive classroom environments involves the development of knowledgeable, empathetic practitioners who can recognise and support the child who has selective mutism and enable curricular and social progress within school.

REFERENCES

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th ed), Washington DC: APA.

Bassey, M. (1999) *Case Study Research in Educational Settings*, Buckingham: Open University Press.

Cline, T. and Baldwin, S. (1994) *Selective Mutism in Children*, London: Whurr.

Johnson, M. and Wintgens, A. (2001) *The Selective Mutism Resource Manual*, Oxon: Speechmark Publishing Ltd.

Lebrun, Y. (1990) *Mutism*, London: Whurr.

O'Neill, F. (2005) Understanding and Supporting Children with Selective Mutism in the Primary School, *REACH Journal of Special Needs Education in Ireland*, Vol. 19 (1), 45-56.

Pionek-Stone, B., Kratochwill, T., Sladezcek, I. and Serlin, R. (2002) Treatment of Selective Mutism: A Best-Evidence Synthesis, *School Psychology Quarterly*, Vol. 17 (2), 168-190.

Websites accessed:
www.selectivemutism.org (19th April 2003).

www.asha.org/speech/disabilities/Selective-Mutism.cfm (19th April 2003).
www.acposb.on.ca/mutism.html (25th April 2003).