Understanding and Supporting Children with Selective Mutism in the Primary School

Although selective mutism is not a common condition, it can have very serious effects on a child's academic and social life. Following a description of selective mutism and the most commonly observed characteristics of children who present with this condition, a process of identification and intervention is presented, based on a mainstream setting and involving the support of a resource teacher, amongst others.

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INTRODUCTION

Mutism is not a new phenomenon; references to mutism are found in the bible and it is a recurring theme in Greek and Roman poetry and in modern literature and film. Mutism presents in many forms – organic mutism resulting from a physical impediment, hysterical mutism resulting from trauma such as that experienced by frontline soldiers and, finally, selective mutism. Children who are selectively mute are unable to speak to others in situations where they feel insecure and exposed but relate normally in other situations. It is an extremely rare disorder and while many educators may not be familiar with the term selective mutism, most will have observed a child in their school who did not speak to others during part, or indeed all, of their time there. As selective mutism generally presents in the school setting and not at home, parents may be unaware of the extent of their child's mutism and its impact on the child's school life. As much of our curriculum is delivered in an interactive way, selectively mute children are, therefore, at a distinct disadvantage.

It is important for educators to know that mutism is a seriously debilitating disorder and to be aware of the importance of referring children to the relevant agencies for assessment and early intervention. Early intervention is essential as once mutism becomes entrenched it is more difficult to overcome. It is also important for teachers to know and understand the disorder and take a proactive role alongside other professionals to help selectively mute children overcome their fear of speaking and cope with their anxieties.

It is hoped that this paper will provide some insight into the life of selectively mute children and the challenges they present. It aims to show how an ordinary teacher without specialist training might begin to help a child with selective mutism to happily engage with others at school.

WHAT IS SELECTIVE MUTISM?

Children with selective mutism are unable to speak in specific social settings but speak freely in situations where they feel comfortable and secure. In accordance with the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV, 1994), the following criteria must be met before a diagnosis of selective mutism can be made:

A. Consistent failure to speak in specific social situations (in which there is an expectation for speaking, e.g., at school) despite speaking in other situations.
B. The disturbance interferes with educational or occupational achievement or with social communication.
C. The duration of the disturbance is at least 1 month (not limited to the first month of school).
D. The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
E. The disturbance is not better accounted for by a Communication Disorder (e.g., Stuttering) and does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder. (p.115)

INCIDENCE AND ONSET

Selective mutism is a very rare condition, affecting less than one percent of the clinical population according to Ford, Kratochwill, Sladezcec and Carlson's 1998 study (cited in Pionek-Stone, Kratochwill, Sladezcek and Serlin, 2002). A survey of educational psychologists in Sussex by Buck in 1998 (cited in Imich, 1998), showed that an educational psychologist is likely to encounter one child with selective mutism every five years. However, Johnson and Wintgens (2001) suggest that these figures may not reflect the true number of cases as these children remain quiet and unobtrusive and consequently may not be referred for assessment.

Studies show that, unlike attention deficit hyperactivity disorder and language impairment, more girls than boys are affected by selective mutism (Cline and Baldwin, 1994). Recent studies have shown that it is not linked to parenting or family dysfunction (Cunningham, McHolm, Boyle and Patel, 2004). However, Hultquist, (1995) cites a previous study in 1980 by Hayden that notes that all families in that study had substantial pathology, for example, child abuse. Studies by Krohn, Weckstein and Wright in 1992, also cited by Hultquist, reported the association between selective mutism and parental use of silence to display hostility, pathological shyness or anxiety in parents and marital discord. Selective mutism presents in children from all social backgrounds and with all levels of intelligence. The age of onset, three to five years, coincides with the time children separate from their parents and enter the more formal environment of play school or primary school. However, referral is not always prompt with some studies reporting a delay of up to eight years before a referral was made, according to Hultquist.

FEATURES ASSOCIATED WITH SELECTIVE MUTISM

Psychiatric Problems

There is some debate as to whether selective mutism is a stand-alone disorder as defined by the criteria listed in the DSM-IV (1994), or a symptom of anxiety disorder or social phobia. In studies by Black and Uhde in 1995 and Dummit et al. in 1997 (cited by Johnson and Wintgens, 2001) virtually all of the children met the criteria for

social phobia or avoidant anxiety. Enuresis, depression and obsessive-compulsive features have also been associated with selective mutism.

Personality

Anxiety, wariness, timidity and hypersensitivity are common personality traits of the child with selective mutism at school, often accompanied by inflexibility. The child may like to please but may be unable to initiate or respond spontaneously. In contrast, parents report that these children "can be boisterous, funny, extremely verbal and even bossy at home" (http://www.nasponline.org/futures/selmutism.html). Children with selective mutism show signs of anxiety before and during most social events and fear performance and the expectation of social interaction. When faced with a situation where speech may be expected they are likely to panic, become rigid with fear and then withdraw. Shipon-Blum concludes that they are, "so anxious that they literally freeze, are expressionless, unemotional and often, socially isolated" (http://www.nasponline.org/futures/selmutism.html).

Language Impairment

While language impairment often co-exists, it is difficult to clinically assess expressive language in a child with selective mutism. Shipon-Blum maintains, "that a proportion of selectively mute children have been exposed to another language during formative language development (ages 2- 4years)". She states that "these children are usually innately temperamentally inhibited (prone to shyness and anxiety) and the additional stress of speaking another language and being insecure with their skills is enough to cause an increased anxiety level and mutism"(http://www.nasponline.org/futures/selmutism.html). Teachers of international students also report that it is not uncommon for children to have a silent period when they enter school with no prior knowledge of the language.

Genetic Factors

A case history often reveals a family history of shyness or selective mutism and research is ongoing to determine whether the cause is genetic or environmental. Johnson and Wintgens (2001) cite a 1997 study by Steinhausen and Adamek that suggests that genetic factors play a role. A collaborative study currently being undertaken by Dr. Elisa Shipon-Blum (*Selective Mutism Group-Childhood Anxiety Network, Inc.*) and Dr. Murray Stein (University of California, San Diego) aims to examine the relationship between Social Anxiety Disorder and serotonin genes.

FACTORS THAT PRECIPITATE SELECTIVE MUTISM

There appears to be no clear evidence that any one thing causes selective mutism. Researchers generally conclude that a combination of genetic and environmental factors play a role but acknowledge that it is difficult to separate the two. Genetically, children may be predisposed to speech and language impairment, shyness or anxiety, and these, in conjunction with environmental factors such as separation, loss, school admission, teasing, self awareness of speech impairment, or migration may precipitate selective mutism (Johnson and Wintgens, 2001). Selective mutism prevents children from interacting freely with and responding spontaneously to their social and learning environments. It can also cause great distress and frustration to the adults responsible for their care.

THE DYNAMICS OF SELECTIVE MUTISM

The dynamics of selective mutism vary from case to case and theorists interpret children's mutism according to their professional perspectives, psychodynamic or behaviourist. A child who remains silent in order to avoid the negative feelings of anxiety and the embarrassment they associate with speaking may be seen by some as manipulating and controlling their environment and by others as protecting themselves from it in order to survive. Lebrun (1990) notes that some children, "seem to be using their mutism to keep others at a distance, they resemble small animals which freeze in the presence of danger" (p. 21). Johnson and Wintgens (2001) concur with this view, believing that "self-protection rather than deliberate opposition" are the motivating factors in selective mutism (p. 18). However, Lebrun also notes that sometimes mutism may be an oppositional expression of hostility, a protest against being left in a situation in which a child is having difficulty coping. Lumb and Wolff (cited by Imich, 1998) referred to two types of selective mutism, manipulative and anxiety driven, and the need to differentiate between them when planning an intervention.

FACTORS THAT MAINTAIN SELECTIVE MUTISM

Many factors combine to establish selective mutism and maintain it as a mechanism for avoiding the anxiety associated with speaking. A number of factors have been identified by Johnson and Wintgens (2001) as likely to reinforce mutism. These include increased attention and affection towards the selectively mute child, over-acceptance of the mutism, negative models of communication within the family and lack of appropriate intervention or management. There is general agreement that spontaneous remission is very rare (Imich, 1998) so appropriate intervention is essential if academic, social and emotional problems are to be minimised.

TREATMENT APPROACHES TO SELECTIVE MUTISM

Documented research describes a variety of approaches to help the child who has selective mutism. However, as Pionek-Stone et al. (2002) note, such research tends to involve single case studies thereby making it difficult to draw general conclusions regarding the most successful type of intervention. The following are the principal approaches described in the literature.

The Psychodynamic Approach

The psychodynamic approach to intervention regards selective mutism as the manifestation of underlying issues or conflicts. These issues are explored with the child through a combination of play and art therapy and it is believed that once they are resolved the child will communicate normally. Successful outcomes involving the exclusive use of this approach are limited, perhaps because treatment generally takes place in a clinic and selective mutism tends to be situation specific.

Family Therapy

Family therapy views the family as central to the child's social system and treatment involves harmonising the communication within the family unit. This bonding may be

helpful in conjunction with other approaches but, as selective mutism generally occurs outside the home, the value of exclusive family therapy is limited.

Pharmacotherapy
Pharmacotherapy involves the use of medication, such as Prozac, a serotonin reuptake inhibitor (SSRI). It is believed that by using medication to reduce anxiety the child will respond more easily to behavioural intervention.

Speech and Language Therapy
Some children with selective mutism have language or speech deficits. However, traditional speech and language therapy, when provided in group sessions, tends to be unsuccessful. The anxiety such a format generates in the child may prevent him from engaging with the group.

Behavioural Methods
Underlying behavioural approaches to intervention are based on the belief that selective mutism results from negatively reinforced patterns of behaviour. Consequently, behavioural intervention employs strategies such as positive reinforcement, stimulus fading, shaping and modelling. These are often combined with cognitive behaviour modification strategies such as self-talk and modelling. Having analysed the available research, Pionek-Stone et al. (2002) have concluded that behaviourally oriented treatment approaches to intervention provide a good outcome for the child with selective mutism. In line with this finding, Johnson and Wintgens (2001) provide a programme based on behavioural principles; this manual is a useful guide to planning an intervention. Many factors combine to influence the style and pace of intervention - the child's cognitive level, his personality, the extent of his mutism and the length of time he has been mute. Also relevant is the child's age, home support, available personnel and the setting in which intervention will take place.

EVALUATING THE NEEDS OF A CHILD WITH SELECTIVE MUTISM

It is important to collate all the available information about the child so that it may inform the planning for intervention. The psychologist will carry out a formal assessment in order to ascertain the child's level of cognitive functioning. The psychiatrist will evaluate the emotional development of the child and look at the family context. A speech and language therapist will endeavour to determine if there is a deficit in that area. Former teachers may provide information about learning style and learning strengths and needs. Parents can provide insights into the child behind the anxiety; what s/he finds enjoyable and interesting. Information regarding the child's relationship with her/his siblings, early development and patterns of communication will also be valuable.

Following assessments and initial meetings the psychologist, the class teacher and the resource teacher would meet to collate the information and draw up a plan for the child. Decisions need to be reached regarding who will be involved in implementing the plan, where the intervention will take place, whether the child will work alone, with a peer group or a combination of both and whether areas of the curriculum need to be supported in order to facilitate participation in class.

THE INTERVENTION TEAM

Intervention must be motivated by the desire to understand the child and ease his/her anxiety. Empathy and total acceptance of the child's difficulty with speaking is essential lest the process become a power struggle between the intervener and the child. Confrontation is ineffective and may serve to delay a successful outcome. Committed, optimistic adults who are guided by the child's responses are her/ his greatest asset.

The Psychologist

The psychologist plays a pivotal role in the intervention process. It is s/he who assesses the child and together with the child psychiatrist reaches a diagnosis of selective mutism. Ideally, s/he is involved in educating, advising and supporting the child's parents and teachers. However bearing in mind that a psychologist is likely to meet only one case of selective mutism every five years it is possible that not all will have experience in the field to contribute in this way.

Parents

Parents are certainly involved in the process and they have a very valuable contribution to make. Understandably, they may be shocked and quite unprepared for the diagnosis and become very emotional. Unless a teacher has understood the debilitating effect of mutism and has kept them informed, they are unlikely to understand its impact. They may see their child as merely shy in public and fine at home. Their personal lives and those of their children become public as professionals seek to understand the reason for their child's mutism. They search for answers and none may be forthcoming. It is important to spend time building rapport with them and encourage them to participate as equals in the process of finding a way to ease their child's anxiety, rather than presenting them with a readymade plan.

School Staff

All school staff are involved in the process of intervention; the principal, class teachers, special education support teachers, special needs assistants, the caretaker and the school secretary all have a part to play. It is likely that the resource teacher will become the co-ordinator of the school team taking responsibility for liaising with all involved, educating staff and supporting the class teacher. It is imperative that the resource teacher involve all in building an environment of trust and respect, in which the child might, at some point, feel comfortable speaking.

Children

Children are a great asset to the intervention process. Friendships need careful nurturing both at home and at school as they have a very positive and powerful effect on the self-esteem of the child. The child is of course the central focus of the intervention process. Her/his changing needs need to be constantly monitored and the plan adjusted accordingly. It is essential that communication between the people involved in the intervention process is regular, open, honest and mutually supportive.

CREATING THE RIGHT ENVIRONMENT

Most children would enjoy the attention of a smiling adult who came down to their level and chatted to them and maybe even shared something with them. However, for the child with selective mutism, direct questioning, physical proximity and being the focus of someone's attention may be very stressful indeed. The right environment is one that will give him confidence and security, one where speech is expected but not demanded. All involved in an intervention need to have the skills necessary to make this a reality. Knowledge of the following strategies will help the adults to engage with confidence.

- Spend time observing and building rapport.
- Respect the child's personal space and don't sit facing him.
- Provide a choice of activities, including something practical. Manipulating blocks or play dough often helps to relieve anxiety.
- Recognise when the child is anxious and be prepared to change the direction and pace of the task as necessary.
- Remain low key, almost nonchalant, but in a matter of fact way communicate the expectation that the child will engage.
- Don't cajole or pressurise the child into speaking as this will heighten his anxiety.
- Don't flatter him or make a fuss if he speaks.
- Avoid asking direct questions and putting the child on the spot.
- Work alongside the child, let him set the pace.
- Appear to be talking to yourself, make comments such as, "I suppose…; maybe if…; I wonder…; It looks as though…". These will provide opportunities for the child to respond if he feels ready.

Finally, it is important to remember that it may not always be possible to maintain the perfect environment for the child. If, however, we show that we truly accept that the child wants to speak but cannot, s/he will feel secure.

THE PLANNING FRAMEWORK

In their manual for the treatment of selective mutism, Johnson and Wintgens (2001) offer a behavioural programme, a progressive treatment plan. It considers five phases in the treatment process. Each phase is linked to stages of confident speaking, ranging from no communication or participation through to the use of connected speech with a key worker and, finally, generalised communication. Intervention goals are outlined for each stage and there is a menu of activities that might be comfortably undertaken by the child. The communication load of verbal activities is also presented in progressive order from low to high. This plan provides a framework on which to base an intervention for any child at any stage of selective mutism. It allows one to see the child's needs and work towards specific goals at the child's pace. Stimulus fading and positive reinforcement are the strategies recommended. It is vitally important that those working closely with the child are familiar with the stages so that they may understand the intervention process and actively support it.

THE FIVE PHASES OF THE TREATMENT PROCESS

Building Rapport

During this phase of the intervention it is important to spend time building a relationship of trust with the child. The child engages in non-threatening, playful activities where speech is not demanded or required, but the relationship conveys an expectation of it. The resource teacher might begin by making occasional visits to the child's class, chatting to children, bringing them to her/his room for an activity, returning them and gradually moving alongside the child with selective mutism. Later when the child seems ready, s/he could be invited to accompany others to the resource room for an activity. Later still he could be invited to attend on his own and, as engagement with the resource teacher becomes more relaxed, the session times could be extended and new activities faded in.

Making the Child an Active Partner

When working with a child with selective mutism it is recommended to acknowledge the child's difficulty speaking and assure them that it will not always be like this. However some children may be unable to verbalise their anxiety and it may more prudent not to acknowledge or label it so that an authentic matter of fact expectation of speech may be conveyed. A finishing time should be pre-arranged and the child should not be coaxed to do something they are not comfortable with.

Eliciting Speech

It is vital that activities are lively and fun and that speech is secondary to the enjoyment of the activity. Once rapport and trust have been established and the child is at ease with his environment, the child moves from gesture as a form of communication to faintly whispering single words and then phrases. Before true dialogue is established, a monologue phase has been observed, when the child will speak with confidence about a topic s/he has an interest in but is unable to accommodate the listener's questions or comments. Social reinforcers such as smiles of approval are useful rewards but it is important not to make a fuss of the child when s/he begins to speak.

Generalising speech

Eliciting speech is the primary goal of intervention. Once established with one person, the team works towards generalising speech using stimulus fading and shaping techniques. With support the child may move to explore all areas of the school and those who work there. New people are faded in by changing one variable at a time, thereby enabling the child to move through the stages of confident speaking. This stage is also concerned with helping the child move beyond responding to a familiar situation to initiating, presenting information and dealing with unplanned events. For example, a child may be first asked to bring a written message to another teacher, later a written message requiring a verbal response, later still a verbal message. It is essential to prepare the child for various scenarios for example if the class are not in their room or if the teacher is talking to another adult and of course it is imperative that the class teacher be prepared for the child's visit. Skills mastered in the resource room setting tend not to transfer immediately to the wider school community but follow a little later.

Letting go

Progress will be evident in the changing demeanour of the child. The ability to share a joke, laugh out loud, enjoy the company of peers and be less wary of others are all positive indicators. As speech is generalised across a range of settings and a range of people, support should be gradually reduced. Curricular support may still be required, depending on the individual child and sensitivity to her/his anxieties should be maintained. When a child with selective mutism transfers successfully to a new class year s/he is generally considered to be free from the anxiety of speaking.

SUMMARY

In summary, the following ten points may help to guide resource teachers who are working to alleviate the suffering of selectively mute children.

1. Be informed; know the child and know how to intervene.
2. Build a professional intervention team to facilitate the sharing of knowledge and expertise.
3. Spend time building rapport and trust with the child and her/his parents.
4. Support the class teacher; it may not always be possible to remember the appropriate language when faced with the demands of a busy classroom.
5. Create a positive, respectful, supportive environment accepting that selective mutism results from, "self protection rather than deliberate opposition" (Johnson and Wintgens, 2001, p.18)
6. Adopt a calm, matter of fact approach, do not fuss and flatter the child.
7. Remember to comment rather than question.
8. Provide curricular support to enable the child to participate with confidence in class work. Pre-teach new topics.
9. Regularly evaluate the direction of the programme and ensure the needs of the child remain central to it.
10. Know when it is time to let the child go and celebrate his/her independence.

CONCLUSION

Selective mutism is a very debilitating condition that offends the essence of what it is to be a child. In the absence of information and guidance many educators have observed children imprisoned by fear and have felt unable to help. However, my belief is that with knowledge, understanding and empathy, ordinary teachers in ordinary schools can make a difference to children with selective mutism.

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