

Selective Mutism

Handout

Sabrina Colborn
University of Pittsburgh

Table of Contents

Glossary	3
What is Selective Mutism (SM)?	4
Signs of Children with Selective Mutism	
Causes of Misdiagnoses	
If Not Diagnosed	
Communication Strategies for You as the Teacher	
Implementations for the Classroom	5
How to Help the Parent	
Additional Information	
Case study	6
Book Recommendations	7
Other Resources	8
Annotated Bibliography	9

Glossary

Social Phobia/Social Anxiety: a strong fear of being judged by others and of being embarrassed. (National Institute of Mental Health)

Contingency Management: (operant conditioning methods such as positive reinforcement to modify behavior)

Positive Reinforcement: actively identifying behaviors that you want to see more of.

*from the PowerPoint, there was the mention to use a Token Economy: a system of positive reinforcement that can encourage desired behaviors or discourage undesirable behaviors by providing a token that can be cashed in for a desired reward.

Self-monitoring contract: are designed to assist an individual to self-reflect and regulate their behavior

Shaping: gradually leading an individual towards a desired behavior.

Successive Approximation: systematic progression toward a goal

Stimulus Fading: The gradual removal of discriminative stimuli

WHAT IS SELECTIVE MUTISM (SM)?

- Associated with Social Phobia and Anxiety
- What does it look like? The child will not communicate in different situations. Most children will speak to close family members but not to teachers or peers.
- Noticing failure to speech is longer than 1 month, not including the first month of starting school
- Prevalent: Females than males and children between 3-6 years old.

SIGNS OF CHILDREN WITH SM

- Related to those with anxiety
- Amplified separation anxiety, especially away from their parents
- Shy behaviors
- Slow-to warm temperament

CAUSES OF MISDIAGNOSES

- Because the child speaks at home and parents might say, they are just shy.
- Second language learners are missed diagnosed because they go through a “silent period.”

IF NOT DIAGNOSED

- Selective Mutism and other anxiety will become worse over time.
- It may affect academic and social development. About 32% will perform below grade level. (Cunningham, McHolm, Boyle, & Patel (2004).
- Eventually it will become a part of the child’s identity.
- Developmental delays of speech and language.

COMMUNICATION STRATEGIES

- Avoid closed yes/ no questions
- Calling on the child rather than waiting for them to volunteer
- Providing “wait time” (3-5 seconds) for response
- Creating small group class activities with verbal responding
- Try to avoid non-verbal responses (head nodding, pointing or writing instead of speaking)

* Do not create excessive anxiety by pressuring or forcing a child to speak

IMPLEMENTATIONS FOR THE CLASSROOM

- Contingency management (positively reinforce all signs of verbal behavior while ignoring nonverbal behavior)
 - Token economy
- Shaping- gradually leading an individual toward a desired behavior
- Successive approximation- systematic progression toward a goal
- Stimulus fading- the gradual removal of discriminative stimuli

HOW TO HELP THE PARENT/CAREGIVER

- Suggest caregivers to make a visit to school before the child enters for the upcoming school year.
 - That way the child will have a chance to meet with the teacher and be familiar with the new setting
- Suggest books from the Children Books that they may read to their child a well.

ADDITIONAL INFORMATION

- Children with Selective Mutism might become victimized because of their shyness
- Children will be able to perform academically normal and function just like their peers.

Case Study

Nola is a 4 year old who attends preschool. At home, Nola is a talkative, high-energy child, even as a toddler she would always be making noises. Lately Nola will become quiet in public situations and her parents think that she is just being shy. One day Mrs. Moss notices that Nola interaction changes from how she acts with her parents during drop off and how she acts once she enters the classroom. Nola stays quiet and to herself during class time. During that day, her teacher notices Nola talking to a baby doll in the dramatic play area. However, if another classmate or Mrs. Moss, herself comes close to Nola, she will become quiet. Nola has been acting like this more than a month or so. Mrs. Moss talks with the parent to see if they notices the difference in Nola's interaction with other settings where she becomes quiet. Her parents notice that she does become quiet in different situations other than home, such as at church and out in public when others are around. Her parents thought that she might just be shyness and figures that she will just grow out of it.

Children Book Recommendations

A Home for Bird by Philip C. Stead

Vernon the toad finds a new friend in a small blue bird that is silent. Vernon shows all the wonder of the forest, but the Bird doesn't say anything. Vernon introduces Bird to friend, but the Bird still doesn't talk. Vernon is worry that Bird's silent because he misses home. The two set off on a journey to help Bird find his home. (Amazon)

Cat's Got Your Tongue?: A Story for Children Afraid to Speak By Charles E. Schaefer and Judith Friedman

Chatterbox Jamie by Nancy Evans Cooney

Jaime is excited about to start nursery school. At home all he talks about is the first day of school. However, when the first day arrives Jaime is too shy to speak. He spends most of the day sitting on the side watch everyone around him. Finally, a classmate younger visits and Jaime remembers him of his little sister. He all of sudden, Jaime cannot stop talking. (Barnes & Noble)

Danny the Duck with no Quack by Malachy Doyle

Shy Danny the duck goes in look for of his missing quack, only to find that it takes two tricky foxes to solve the problem. (Amazon)

Lola's Words Disappears by Elaheh Bos

Lola starts schools and her words have disappeared. Lola has to find the courage to retrieve her words. (Barnes & Noble)

Maya's Voice by Wen-Wen Cheng

Maya enjoys talking in her sweet voice. Until she starts school and she loses the confidence in speaking. She ends up spending her school day in silence. Time and patience, Maya is able to finally speak in her sweet voice again. (Barnes & Noble)

My Friend Daniel Doesn't Talk by Sharon L Longo and Jane Bottomley

Ryan meets Daniel, a boy who is too scared to talk in school. Ryan become friends with Daniel and defends him in school to the other classmates. From the growing friendship made, Daniel is able to start talk to Ryan. Ryan hopes that one day that Daniel will be able to talk in school and have everyone round them know who the real Daniel is. (Amazon)

Too Shy for Show & Tell by Beth Bracken and Jennifer A. Bell

Sam is a quiet boy who hates show-and-tell. Thinking about it makes his stomach upset Sam has to find an approach to overcome his fear of show-and-tell. (Barnes & Noble)

Understanding Katie by Elisa Shipon- Blum

Other Resources

Selective Mutism Foundation

Website: <http://www.selectivemutismfoundation.org>

Selective Mutism Treatment and Research Center SMC

Website: <http://www.selective-mutism.org/>

Child Mind Institute

Website: <http://www.childmind.org/en/health/disorder-guide/selective-mutism>

Annotated Bibliography

Busse, R. T., & Downey, J. (2011). Selective Mutism: A three-tiered approach to prevention and intervention. *Contemporary School Psychology: Formerly "The California School Psychologist"*, 15(1), 53-63.

Researchers have found that selective mutism (SM) can be associated with social phobia. At times SM is caused from a trauma experiences, such as hostile home environment, physical or sexual abuse, or tragic events like a death of a loved one. SM is more prevalent in females than in males, and appears in children from age three to six years old. The majority of referrals occur during the first years of school. Children with an immigrant background are more likely to be diagnosed with SM. However, these children are often misdiagnosed because of they are learning a second language and going through a "silent period."

This article mentions a three-tiered approach to prevention and intervention of selective mutism. Tier one focuses on expanding awareness of SM, training teachers on communication strategies to be used in the classroom to minimize the anxiety associated with the school environment. Without proper awareness of SM and other anxiety will become worse of time. It may affect academic and social development and may become a part of the child's identity if not treated. For you as the teacher, communication strategies consist of speaking and providing opportunities to respond. Avoid using closed yes/no questions. Call on the child rather than waiting for them to volunteer and provide a "wait time" (3-5 seconds) for response. Create small group class activities with verbal responding. Try to avoid non verbal responses, such as head nodding, pointing or not writing in lieu of speaking. In addition, try these methods on the first day of class or as soon as possible. Do not wait for the child to start speaking. However, do not create excessive anxiety by pressuring or forcing a child to speak. Another way to reduce SM or have a child develop SM is by preparing them for the transition to school. If a child is in your class and is about to enter into grade school the following year, suggest that caregivers to make a visit to that school. Although some preschool children may not develop SM until kindergarten, characteristics relating to SM should be acknowledged and monitored.

Tier two introduces the idea of interventions for children that are at-risk for SM. Signs for children at-risk for SM are behavior related to anxiety, such as amplified separation anxiety, shy behaviors, and slow-to warm temperament. Schools may offer a Selective Mutism Questionnaire to caregivers regarding the level of communication and anxiety that their child displays. As the teacher, you and the caregivers, along with supportive personal and the school psychologist can attempt an implementation for the classroom along with home-based strategies. As mentioned in tier one, including opportunities to respond, contingency management (positively reinforce all signs of verbal behavior while ignoring nonverbal behavior), shaping, successive approximation (showing effective strategies that are gradually working to have child(ren) speaking), and monitoring. In addition to these methods, group therapy might be an option for intervention. Bring together children with possible shyness and other anxiety related problems and focus on nonverbal and verbal goals (making eye contact, saying hello when greeted, responding yes or no, and intimating conversation).

Tier three brings the idea of a variety of individual treatments, including psychoanalysis, behavior therapy, and cognitive-behavioral therapy. The focus of psychoanalysis focus is to understand past events that have occurred for the child to stop speaking and to

work together with the family. Strategies in these areas involve family therapy and play therapy. Behavioral and cognitive-behavioral therapy is more successful in treating SM. Strategies include contingency management, shaping, social skills training, stimulus fading, systematic desensitization, relaxation training, and self-modeling. As mentioned before contingency management involves operant conditioning methods such as positive reinforcement to modify behavior. As a teacher you may use a token economy. Shaping is a common strategy that offers small steps of success for target behaviors to be reinforced. Stimulus fading is where the child is in control of the situation. The child as a caregiver around and is comfortable to speak with them. From there the teacher or someone that the child is not comfortable with will slowly be added into the situation. Systematic desensitization and relaxation therapy is exposing the child to high levels of stimulation and reducing the level of anxiety, reproducing improved outcome, such as starting to whisper, to speaking in small groups and eventually speaking in front of the whole class. Self-modeling involves the child to record themselves speaking on video or audio devices and using that recording in the setting in which they would not normally speak. This exposure will increase their awareness of the anxiety which may result in more comfort that allows them to speak.

Carbone, D., Schmidt, L. A., Cunningham, C. C., McHolm, A. E., Edison, S., Pierre, J. S., & 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(8), 1057-1067.

Selective mutism (SM) is the failure to speak in certain situations even though speech is present in other social situations. Students from an immigrant background would be higher labeled with SM. There is little evidence that shows which sex is diagnosed with disorder. However, reports show that females might be higher than males. The typical onset of SM is before the age of five and is not evident until the entry of school or where pressure to speak increases. Referrals for children with possible SM are not made until the child is about 6.5 to 9 years old. SM can last several months of a few years. Adults diagnosed with SM as a child often continue to have social anxiety.

SM is classified as a social anxiety. Children with have relatives with SM have a greater chance this becoming a genetic factor of this disorder. Children with SM and anxiety disorders have similar temperaments. Mostly common is behavioral inhibition. Children with SM show lower social competence compared to their developed peers.

Chavira, D. A., Shipon-Blum, E., Hitchcock, C., Cohan, S., & Stein, M. B. (2007). Selective mutism and social anxiety disorder: all in the family?. *Journal of the American Academy of Child & Adolescent Psychiatry*, 46(11), 1464-1472.

Selective Mutism typically starts in early childhood, often during the preschool years when a child is required to speak in formal setting. There is little evidence that states children exposed to over controlling or hostile parenting or exposed to a traumatic event would have SM. SM and social anxiety share the same characteristics such as shyness, anxiousness, and withdrawal. In this study, researchers look to see if children with SM are likely to have this disorder from their parents with similar behavioral problems (avoidant personality disorder (AVPD) or generalized social phobias (GSP). It has been shown that 87.5% of parents with SM have a lifetime generalized social phobia

diagnosis. With small data supported, it is concluded that SM is related to AVPD and GSP and has a familial and likely a heritable component. Fathers of children with SM appear to have more social phobia and avoidant personality disorder than mothers. Fathers with severe form of social phobia can result that their offspring will have social phobia or selective mutism. If SM has a heritable component, then there is the likelihood that traits of neuroticism or temperamental characteristics are transmitted as well.

Cunningham, C. E., McHolm, A., Boyle, M. H., & Patel, S. (2004). Behavioral and emotional adjustment, family functioning, academic performance, and social relationships in children with selective mutism. *Journal of Child Psychology and Psychiatry*, 45(8), 1363-1372.

This article addresses common questions relating to SM; Is SM associated with anxiety or oppositional behavior? Is SM associated with parenting and family dysfunctions? Will my child fail at school? Will my child make friends or be teased and bullied?

SM child showed high level of anxiety –related disorders and SM can be labeled as a form of social phobia. Oppositional behavior is common among children with SM. SM can be linked with stressful situations with children. Most students with SM do well academically. However, 32% perform below grade level. Children with SM are more likely is victimized by peers often due to their shyness and inhibitions.

This study looked at 104 children, 52 with SM and 52 community controls. After the study, children with SM scored higher levels of anxiety and OCD than the community control group. There were no differences in family functioning and parental depression in SM children and control group. Looking at academic performance between these two groups, neither group performed better than the other. Even activities at home related to academics showed no differences. Finally the children with SM and the children in the control group were able to play with peers outside of school and participate in afterschool activities without any problems.

Children with SM are able to function normally just like other peers of their age. Teachers and parents should not underestimate the child with SM.

Cunningham, C. E., McHolm, A. E., & Boyle, M. H. (2006). 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*, 15(5), 245-255.

Selective mutism occurs in 2% of early elementary school children and in the female population. SM children will speak to immediate family members, selected adults in the community, peers on the playground, but not to teachers. As mentioned from other articles, children with SM may show OCD characteristics. Children with SM are likely to be more anxious when separated from their parents at school. In addition, children with SM may be less likely to participate in extracurricular social activities that build peer relationships and provide conversational exposures that reduce anxiety.

Sharp, W. G., Sherman, C., & Gross, A. M. (2007). Selective mutism and anxiety: A review of the current conceptualization of the disorder. *Journal of anxiety disorders, 21*(4), 568-579.

There is a need for children with SM to be screened as early as possible. Parents underestimate that their child might just be shy or have a slow-to-warm temperament relating to others in a social setting. There are high rates of shyness; social phobia and social avoidance in children with SM. A large percentage of these children meet the criteria for a developmental disorder or delay (cognitive, speech-language, or motor delay) suggesting that SM may be associated with developmental disorders as often as anxiety disorders. Children diagnosed with SM as a child may struggle with symptoms of shyness and social anxiety into adolescence and adulthood. Social anxiety may continue even if mutism disappears.

Steinhausen, H. C., Wachter, M., Laimböck, K., & Metzke, C. W. (2006). A long-term outcome study of selective mutism in childhood. *Journal of Child Psychology and Psychiatry, 47*(7), 751-756.

Aphasia voluntaria identified by the German physician Kussmaul in 1877 was changed to elective mutism in 1934 by the Swiss pioneer of child psychiatry, Moritz Tramer. This study looked at children who were diagnosed at the age of 8.5 with SM. Results found that some risk factors related to SM included developmental delays of speech and language and bilingualism and migration. SM did not change considerably across time and in which the symptoms disappear quite suddenly in adolescence or youth adult.

Viana, A. G., Beidel, D. C., & Rabian, B. (2009). Selective mutism: a review and integration of the last 15 years. *Clinical Psychology Review, 29*(1), 57-67.

Selective mutism/ elective mutism can be an anxious reaction in response to a threatening environment for a child. SM is concerned a “young child” disorder that is manifested during the ages 2.7- 4.1 years old. SM can be misdiagnosed because the child speaks at home. With early assessment, SM can be prevented and limit functional impairment. There is no cause of SM. However, it is suggested that traits could possibly be inherited from parents with high levels of anxiety. Traumatic events have been suggested as a factor of SM but there is no evidence that support this fact. Children with social phobia and selective mutism show generalized anxiety and social anxiety. Children with SM may still communicate non-verbally and demonstrate pro social communicative behavior (nodding, smiling, giggling).

As the teacher, you play an important source in proving information. You can describe verbal and nonverbal inhabitation in the school setting. You can identify the child that has SM and their peers that speak with whom they speak. Also you may be able to describe situations in which the child is more or less likely to talk. Finally you have the insight regarding former strategies that were successful in remediating the mutism. Direct assessments might be helpful as well as interviewing and observing the child. Observers can watch the child to examine the nature and extent of the impairment. Also watch for any temperaments and the degree to which he or she is able to warm up to strangers. Another assessment that is important is speech and language. Look for any significant deficits in phonetic awareness, receptive language, and grammar ability.

Recording interactions with parents is another assessment. Identify time when the child speaks normally. Evaluate the audio for phonetics, length of utterances, tone, rhythm, and quality of response. This assessment may help identify possible speech problems associated with the existence of muted behavior in other settings.

Some behavioral interventions related to SM that can be used include contingency management, shaping, stimulus fading, systematic desensitization, self-modeling and modeling. Contingency management involves the use of a positive reinforcement contingent upon verbalization. The use of reinforcement may be used as child starts with nonverbal clues and continue to shape into the desired outcome. Stimulus fading can be used by increasing the number of individuals around the child when speaking. Busse and Downing mentioned having the child around the person they are comfortable talking to and introducing a stranger. Once the child becomes comfortable around a new person then slowly remove the first person. In a self-modeling practice, have a recording of the child with SM talking, and then play footage in a setting where they would not normally speak. The child with SM will be able to see the reaction of their peers. This might break the fear of the child being scared of what other might think of them when they speak.

Vecchio, J. L., & Kearney, C. A. (2005). Selective mutism in children: Comparison to youths with and without anxiety disorders. *Journal of Psychopathology and Behavioral Assessment*, 27(1), 31-37.

Selective mutism is the failure to speak in social situations. A diagnosis of SM is necessary if failure to speak continues longer than one month, is not due to language barriers, and interferes with educational or social functioning. SM occurs in less than 1% of the population. Children with SM are described as being shy, timid, reticent, anxious, depressed withdrawn, fearful and inhibited.

In this study Vecchio and Kearney, compared two groups of children with selective mutism and anxiety. Results showed that children with SM closely resemble children with anxiety disorder.

Yeganeh, R., Beidel, D. C., & Turner, S. M. (2006). Selective mutism: more than social anxiety?. *Depression and Anxiety*, 23(3), 117-123.

Children with SM have the ability physically and cognitively to speak but only do so when at home and stay mute in other settings. Unlike other articles, this one mentions that boys and girls are equally likely to have SM appear. Children with SM show high levels of social distress compared to children with social phobias. There is a chance that children with SM might have speech and language disabilities.