

Selective Mutism

Selective mutism, formally known as elective mutism, is a disorder of childhood that is characterized by the persistent lack of speech in at least one social situation, despite the ability to speak in other situations.. Onset of selective mutism typically occurs before a child is 5-years-old. However, it is usually first noticed when the child enters school. Specific features of this disorder are described in the 2000 *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) (pp.125-127) as follows:

- 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.
- The disturbance interferes with educational or occupational achievement or with social communication.
- The duration of the disturbance is at least 1 month (not limited to the first month of school).
- The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
- 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.

Associated Features and Disorders

A number of different psychological and personality features have been associated with selective mutism (e.g., excessive shyness, fear of social embarrassment, social isolation and withdrawal). Different studies identify different features. Even when a group of children with selective mutism in a particular study shows a tendency toward a particular feature, there are still children in the group who do not display that behavior. It is the persistent failure to speak in particular social situations that is the hallmark of selective mutism. There are different degrees of severity for both verbal and nonverbal communication. The severity also may vary from setting to setting. Children with selective mutism usually do not have speech or language problems; however, an associated communication disorder (e.g., articulation or

phonological disorder, receptive or expressive language disorder) may occur. These communication problems though are not the main reason for the mutism.

According to the DSM-IV, children with selective mutism are “almost always given an additional diagnosis of an Anxiety Disorder (especially Social Phobia)” (p. 126).

Assessment

The speech-language pathologist works as part of a collaborative, interdisciplinary team consisting of the pediatrician, a psychologist or psychiatrist, the teacher(s), and the family. The speech-language pathologist will conduct a thorough **parental interview**, as most children who are selectively mute will not talk to the clinician. Use [Find a Professional](#) to locate a speech-language pathologist near you.

This interview seeks information on:

- the child's **symptom history**, especially focusing on the onset of the behaviors. The majority of children with selective mutism do not have a sudden onset of symptoms
- the **degree to which the child is verbally and non-verbally inhibited, which may vary from setting to setting**. Parents may be asked to provide information about the child's relationships with friends or to describe how the child communicates in social situations outside of school (e.g., interacting with other children and adults on the playground or talking on the telephone).
- **associated problems** (e.g., schizophrenia, pervasive developmental disorder) that could be contributing to the failure to speak. It is possible to rule out selective mutism if one of these are present.
- the child's **speech and language development**, as well as current use and comprehension of language. Does the child understand what people say to him or her? Does the child understand questions and follow directions? Is the child able to find the words needed to express ideas? The parent may be asked to describe the child's speech production (i.e., pronunciation of words, quality/tone/pitch of voice, fluency of speech) to help rule out any other speech and language disabilities that could be causing or exacerbating the

mutism. Current studies show that 20-30 percent of children with selective mutism have other speech and language disabilities; however, these are not the cause of the mutism. It is important to address these speech and language difficulties so the child can become more comfortable with communication.

- any **environmental influences** (i.e., learning more than one language at a time or not having adequate language stimulation) that may affect the child's comfort and confidence with the language.
- **family history** of psychiatric (e.g., social phobia, obsessive-compulsive disorder, or other anxiety disorders) and personality (e.g., extreme shyness) diagnoses that may be predisposing the child to mutism. The clinician reviews the child's medical history to rule out physical problems (e.g., neurological delay) underlying the mutism.

The speech-language pathologist will also review **educational history** via academic reports, parent/teacher comments, and standardized testing. Do these reports indicate concern about the child's communication skills with peers or adults in the classroom? Are teachers concerned about the child's academic achievement? The clinician reviews the reports of any previous testing (e.g., psychological) to assess whether other diagnosed disabilities could be causing or exacerbating the mutism.

The speech-language pathologist will then conduct a **speech and language evaluation**. The child's anxiety level should be taken into account. Accommodations should be considered in order to evaluate the child in comfortable surroundings and with familiar people. A parent might be present to help facilitate communication. If any evaluation procedures are too anxiety provoking they should be discontinued.

- The clinician interviews the child to observe the **quality of verbal and non-verbal communication**. This is done through informal play activities (e.g., playing together with a dollhouse and using the dolls and accessories to stimulate dialogue and social interaction). If the child is having difficulty participating in these play activities, the clinician should try another type of activity. Drawing may be used as a means to explore non-verbal communication skills.

- **Comprehension of language** is evaluated using standardized tests (e.g., the child is shown a set of four pictures and is told to point to one of the pictures) and informal observation.
- The **parent may be asked to do structured communication activities** with the child (e.g., have the child retell the plot of a story or describe a picture) to create an informative videotape. The parent may also be asked to provide a videotape of the child's **speech at home** during regular conversation. These samples enable the speech-language pathologist to evaluate expressive language abilities (word knowledge, use of grammar, ability to sequence a set of ideas, social communication skills). The speech-language pathologist may attempt to conduct an **oral-motor examination** to evaluate the strength and coordination of the muscles in the child's lips, jaw, and tongue. Muscle weakness or incoordination may signify a neurological impairment that is may lead to a diagnosis other than selective mutism.
- **Screening test for hearing and middle ear function** should also be part of the evaluation.

Treatment

The speech-language pathologist may coordinate a **behavioral treatment** program to increase verbalizations. Behavioral treatment is based on the premise that the child who is selectively mute is using the behavior in response to anxiety in social situations. The focus of the speech-language pathologist's intervention is to reinforce communication with a gradual progression from non-verbal to verbal. This may be accomplished through *stimulus fading*, in which the speech-language pathologist sets simple goals (e.g., using a gesture to communicate) and gradually increases expectations until speech is achieved. Another behavioral treatment technique called *shaping* reinforces mouth movements that approximate speech (e.g., whispering) until true speech is achieved. Another technique sometimes used, when the child is willing, is the *self-modeling technique* where the child watches videotapes of himself or herself performing the desired behavior (e.g., communicating effectively at home) to facilitate self-confidence and carry-over of this behavior into the classroom. The speech-language

pathologist should collaborate with the psychologist, whose primary focus will be to help reduce the child's anxiety.

The speech-language pathologist may also work with **specific speech and language problems** that are making the mute behavior worse. For example, some children with selective mutism are afraid to speak because they feel they may say the wrong thing. The speech-language pathologist may use role-playing activities to lessen the child's anxiety and increase confidence with speaking to different listeners in a variety of settings. Other children with selective mutism may not want to speak because they feel their voice "sounds funny." If necessary, the speech-language pathologist may work on speech pronunciation to increase the child's confidence and clarity of speech.

Additionally, the speech-language pathologist likely will work in the child's classroom with teachers to encourage communication and lessen anxiety about speaking. For example, the speech-language pathologist may help the teacher implement the use of small, cooperative groups within the classroom that are less intimidating for the child with selective mutism. Then, the speech-language pathologist will work with the child within this group to facilitate more effective communication with peers, first using non-verbal communication methods, such as signals or cards, to contribute to small group discussions and gradually adding goals to include speech. The speech-language pathologist will work with the child, family, and teachers to generalize learned communication behaviors into other speaking situations. The speech-language pathologist continues to work as part of the school-based interdisciplinary team to treat the child with selective mutism.

The type of intervention will differ depending on the needs of the child and his or her family. The child's treatment may use a combination of strategies, again depending on individual needs.

How Common Is It?

According to the DSM-IV, selective mutism is an apparently rare disorder that affects fewer than 1% of individuals seen in mental health settings. (p. 126).

ASHA Technical Information Packet

Working With Children who Have Selective Mutism

Item #0112293

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