



Selective Mutism
An Integrated Treatment Approach
by Robert L. Schum

Selective mutism is a uniquely challenging childhood communication disorder that demands a coordinated treatment approach. Speech-language pathologists are in an excellent position to coordinate intervention among family, classroom teachers, and other clinicians.

Selective mutism is typically a symptom of an anxiety disorder, requiring treatment in conjunction with mental health professionals. The full impact of the disorder is not usually manifested until the child starts school, and therefore the classroom is frequently where the difficulties are most seriously experienced. Thus, the teacher is often the focal point of the child's most intense symptoms. Because the child usually feels most safe and relaxed at home, practice of good communication skills can be facilitated through the parents. An SLP is the communication expert who is present in the school, whereas the mental health clinician is usually not in the school on a regular basis. The SLP, with knowledge and skills in effective communication treatments, can assume leadership to coordinate an integrated approach for the child among the school staff. Effective treatment of selective mutism requires a highly refined and consistent response among all significant adults around the child. The treatment team consists of at least five members: the child, the parents, the teacher, the psychotherapist, and the SLP.

The Problem

Selective mutism is defined as a failure to speak in specific social situations despite speaking in other situations, and it is typically a symptom of an underlying anxiety disorder. Children with selective mutism can speak normally in certain settings, such as within their home or when they are alone with their parents. However, they fail to speak in other social settings, such as at school or at other places outside their home. Other symptoms associated with selective mutism can include excessive shyness, withdrawal, dependency upon parents, and oppositional behavior. Most cases of selective mutism are not the result of a single traumatic event, but rather are the manifestation of a chronic pattern of anxiety. Mutism is not passive-aggressive behavior. Mute children report that they want to speak in social settings, but are afraid to do so.

It is important to emphasize the underlying anxiety disorder that is the likely origin of selective mutism. Often, one or both parents of a child with selective mutism have a history of anxiety symptoms, including childhood shyness, social anxiety, or panic attacks. This suggests that the child's anxiety represents a familial trend. For some unknown reason, the child converts the anxiety into the mute symptom. The mutism is highly functional for the child in that it reduces anxiety and protects the child from the perceived challenge of social interaction. Treatment of selective mutism should focus on reduction of the general anxiety, rather than focusing only on the mute behaviors.

The school setting frequently offers the greatest challenge for a child with selective mutism. This setting, with many people present and with performance expectations, can heighten the anxiety and therefore cause the protective symptom—mutism—to be exacerbated. A two-pronged approach to treatment is recommended for children who are mute at school:

- individual psychotherapy to help reduce the general anxiety and to practice better communication skills;
- a behavioral program at school to slowly shape increasingly appropriate communication.

An effective program involves a slow, systematic program that rewards successive approximations of social interaction and communication. Mute children cannot be tricked, cajoled, or commanded to speak. These approaches to resolving mutism invariably fail.

Any attempt at improved communication and interaction needs to be noted and reinforced, even if it is nonverbal. This includes making eye contact, following directions, and nonverbal participation in group activities. The successive steps in this approach often need to be quite small. The lack of speech is only the most obvious and dramatic sign of the underlying anxiety. Improvement of the mutism is predicated on a generalized reduction of anxiety. Therefore, reduction of other anxiety symptoms is important and relevant to the treatment of mutism at school.

Treatment Team

Parents will often notice that their preschool-aged child is shy in social situations, but they do not recognize the true extent of the mutism until the child starts school. Sometimes the mutism will be recognized if the child starts preschool and will not talk there. In other circumstances, the child's problem is not identified until beginning kindergarten. If a school SLP or teacher is the first professional to suspect mutism, they should refer the parents and child to a mental health practitioner. A preferred referral is to a child psychologist who can work with the SLP to design a behaviorally based treatment plan, the most effective approach to treating mutism. These professionals can also consider referring the child to a child psychiatrist for a medical evaluation.

Recent medical literature reports use of antidepressants to treat selective mutism in children. Although the reports are promising, they are limited in the number of patients treated and in the behavioral outcomes measured. In my experience, an antidepressant or

an antianxiety medication is sometimes helpful in reducing associated anxiety symptoms, but has been of limited utility in targeting mute behaviors. At this time, parents and professionals should be cautious in their expectations that a medication can "cure" mutism. Rather, it is the responsibility of the psychotherapists and the parents to determine the appropriateness of medication for a young child who is mute.

As a psychotherapist, I establish a specific, systematic hierarchy of speaking situations for my patient. In individual therapy, we practice each step until the child is quite comfortable and spontaneous in that speaking situation. As the child demonstrates comfort in the therapy room with a specific communication behavior, I will recommend that school staff attempt to elicit similar behaviors at school. For example, I might start with children nodding and shaking their heads for yes and no. Then they may proceed to mouthing, but not vocalizing, words for me. Another step may be whispering words or writing them down. In transferring these behaviors from psychotherapy to the classroom, the SLP can help the child practice these in individual and small group treatment, and then shadow the child to help transition the behaviors into the classroom.

The SLP can also use techniques to help reduce the general anxiety of the child with selective mutism through direct intervention and collaboration with the classroom teacher. Routine and structure often help an anxious child. Clearly understanding activities and having a predictable schedule reduce the unknown. If a schedule is changed or a new activity occurs, a preview of this change can be helpful. Anxious children sometimes appear to be "slow to warm up." They might not jump right into a new activity, but first prefer to observe other children doing an activity until they are sure that they understand what to do. Once they engage in the activity, they may require some adult assistance at first, and then have the adult fade the assistance as the child becomes more confident in the skills. For example, in a kickball game, the child might want to first observe other students play, later start playing with adult assistance, and then independently join in.

Specific Treatment Issues

The SLP should be alert to various behaviors that may represent anxiety symptoms. Some children may be resistant to nonverbal activities, such as group activities in physical education class or recess. This may represent unfamiliarity with a new activity and anxiety about participating in something unknown. Some anxious children are resistant to making choices, unless they are quite familiar with a situation. Even as they show improvement in speaking, they may still show the anxiety symptoms of avoidance. If these behaviors occur, the SLP can consult with the psychotherapist and then help the teacher implement methods to involve the child in class activities without exacerbating the anxiety. One of my patients was anxious about any special celebration of her birthday in the classroom, and in therapy we composed a letter to the classroom teacher requesting a modification of the birthday activity so the child would be less anxious.

In working with children who are mute, I usually use terms such as "shy" and "nervous" to

describe feelings when they are reluctant to speak, and "brave" when they extend

themselves in therapy or in the classroom. Most of my patients understand these terms, and I find them helpful to use with teachers and parents.

Selective mutism is often at its height during the important years of reading development. Most children with selective mutism have adequate comprehension and reception in the classroom, but will not speak to name alphabet letters, produce phonics sounds, or read text. This presents a challenge to the teacher in assessment of the child's reading development and suitability for promotion from kindergarten through the primary grades. An SLP can help the teacher develop different methods of assessment of the child's reading abilities. Some children are amenable to a nonverbal assessment technique, such as pointing to letters, but others are initially reluctant to do that. Some children will allow their parents to videotape their reading performance at home, which can then be reviewed by school staff.

An effective treatment technique is to involve the child with peers in various activities. Most of my patients are well accepted by their classmates, even though they are mute. The classmates invite the children to their homes for play or parties and easily accept them, even though the child does not speak to them. The SLP can help identify which peers show a mutual interest in the child. The SLP can collaborate with the teacher to set up instructional situations in which the child is paired with a preferred peer. This peer can also be used in speech and language treatment sessions with the child. Parents can be advised of these developing friendships, so that they can arrange play visits with the peer's parents.

Typically, a child with selective mutism will begin speaking to the peer in the safety of the mute child's home. Next, the child will speak to the peer at the peer's house, if the other parents are not present in the room. Then the peer is often the first person to whom the child will speak at school. This typically occurs in a somewhat isolated setting, such as a quiet area of the playground during recess, or when the two of them are working alone in the building, such as in the library or on an assignment to the school office. The school SLP is a great resource for coordinating these peer events among the various members of the treatment team.

A variation shown by slightly older children with selective mutism is to talk in structured school activities, but then be mute in other circumstances. One of my patients answered teacher questions in class, but could not talk in unstructured situations, such as in the lunchroom or at recess. Rather, she gestured to her peers or wrote them notes. Another patient tried to dominate conversations by maintaining her chosen topic (she was an expert about a TV cartoon series). If an adult changed the topic, the child's anxiety increased and she became mute. In the first case, treatment involved bringing peers into the home and then slowly shaping speaking with peers to other settings. In the second case, therapy involved a shaping procedure of slowly introducing other topics to the conversation on which the patient was an "expert."

Because children with selective mutism often show other anxiety symptoms, another

treatment goal in the schools is to promote more spontaneity in behavior. In individual

therapy, I often use various media to help the child be more spontaneous and less constricted in actions. For example, we draw with markers, cut paper, use modeling compounds, and get messy with finger paints. The approach is to reduce the child's self-consciousness and inhibition. These media also afford the child opportunities to communicate in a nonverbal fashion. One patient of mine started communicating with me by drawing pictures of recent events at home and school. Over the next year, as she learned to read and write, she progressed from labeling the pictures to writing responses to me as we conversed in therapy. We used the creative media as a technique to move her along the communication hierarchy in therapy.

The SLP should know that the duration of mute symptoms is highly variable. I have had young patients show improvement in symptoms in several months, with no more than 12 sessions of therapy. I have had other patients whose symptoms have persisted for several years. I recommend that in consulting with teachers and parents, we caution them that it may take some time until the child is comfortable speaking spontaneously at school and in other social settings.

In this context, it is important to remember that the mutism is only one specific symptom of the social anxiety. Many times we can note improvement in other, nonverbal symptoms of anxiety. If we focus only on the mutism, we can become discouraged by the slow progress in the improvement of that symptom. However, if we take a broader view of the anxiety, we can often identify encouraging progress over a wider array of behaviors. The SLP can be of great help in counseling patience with other members of the team, including parents and teachers.

Summary

Children with selective mutism need psychotherapy to address their anxiety disorder in conjunction with speech and language treatment. If the mutism is first identified in the school setting, the SLP should counsel the parents for a referral to a child psychotherapist who is experienced with this disorder. The SLP can then serve as a key member of the treatment team for this child in two ways—by providing communication treatment and by facilitating interaction among the treatment team.

The SLP can consult with the teacher on different methods of instruction and assessment of the child with selective mutism and can provide focused communication treatment for the child in the school setting. The SLP can facilitate generalization of communication skills from psychotherapy to the school setting, which is usually the most challenging situation for a child with selective mutism. The SLP has a critical role in coordinating the efforts of an entire team. This integrated approach to therapy promises the best opportunity for the child's success.

Additional references can be found in The ASHA Leader Online

at professional.asha.org/news.

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