

BACKGROUND: WHAT IS SELECTIVE MUTISM

Selective mutism (SM) is an anxiety disorder characterized by consistent failure to speak in specific social situations in which there is an expectation for speaking despite speaking in other situations. As defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), this continues for more than one month. Most commonly found in children, they understand spoken language and have the ability to speak when they are in a comfortable setting. Some may have an actual phobia of speaking, as well as a fear of people. Selective mutism is often diagnosed with severe generalized and social anxiety.

The first symptoms of selective mutism are usually noticeable between the ages of one to three years. SM is not usually recognized, however, until the child begins school and is requested to respond verbally and/or interact in social situations, including pre-school, elementary school, and community environments. Sometimes, even then, the child is viewed as shy, and it is assumed that he or she will outgrow the shyness. The cause of this disorder has not been established. However, recent research suggests the possibility of genetic influence or vulnerability for selective mutism.

For those experiencing severe forms of selective mutism, immediate intervention is advisable as the symptoms can increase. Generally speaking, a younger child has a good chance of recovering, if treated, because of the shorter interval of time where no verbalization has occurred in school or

in other major settings. Selective mutism is not a speech disorder nor is it part of the autism spectrum.

(Selective Mutism Foundation.org 2015)

Long-term consequences

- ▶ Difficulties with social interactions and communication
- ▶ Academic difficulties (delayed word decoding and oral reading skills) and long-term educational outcomes
- ▶ Social anxiety into adulthood
- ▶ Difficulties with relationships in adulthood
- ▶ Continued struggles with self-confidence and independence

(Mitchell and Kratochwill 2013; Omdal 2007)

Symptoms

- ▶ Failure to speak in situations where speech is expected
- ▶ Shy/withdrawn; difficulty making eye contact
- ▶ Behavioral inhibition (especially in infancy)
- ▶ Separation anxiety
- ▶ Somatic complaints
- ▶ Obsessions/compulsions
- ▶ Oppositional behavior
- ▶ Depression
- ▶ Struggle with transitions

Suggested accommodations to include on Individualized Education Plans or Section 504 Plans for children diagnosed with a childhood anxiety disorder and selective mutism

- ▶ Have child in an environment that is most appropriate (typically the regular education setting with accommodations)
- ▶ Allow nonverbal communication (pointing, head nods, shakes, thumbs up or down, facial expressions, etc.)
- ▶ Prior preparation or alternatives for presentations
- ▶ Video/audio taping to demonstrate knowledge or as an alternative to presentations
- ▶ Small group work may be beneficial to improve relationships, but know that the child may be nonverbal during these interactions
- ▶ Testing accommodations—For example, recording may be beneficial to improve relationships, but know that the child may be nonverb during these interactions. Consider this sequence of steps: Allow the child to tape their lessons at home. Next, encourage them to tape in a classroom with their parent/guardian present. Encourage them to tape part of a lesson on tape, then whisper the lesson to the parent/guardian (or educator) within the class setting. Next, have them whisper the entire school lesson in the classroom with only the educator present. Increase to another student (a preferred friend), plus the educator. Increase all to verbalization. Each individual step is often a huge leap because the child feels that “the words just won’t come out” even though they desperately want to speak to their peers. Even the slightest successes from the child—including looking at the educator, or coming to the speech room—should be calmly but fully praised by the adult.
- ▶ Related services (emotional support, speech and language therapy, occupational therapy etc.)
- ▶ Do not single out the child
- ▶ Have a classroom routine/structured setting; even an assembly or fire drill can be anxiety producing
- ▶ Have a “safe” place in the room, often one without a view (e.g., a fort-like set up)
- ▶ Do not expect them to talk
- ▶ Don’t comment if the child does talk
- ▶ Seat child in close proximity to a “buddy” or friend
- ▶ Don’t have child be the first to accomplish a demonstration
- ▶ Phrase questions requiring single word responses; you can use a hierarchy of open-ended response, forced-choice response (i.e., was it the bird or the dog?), or single-word response (i.e., the bird?)
- ▶ Do not pressure child for eye contact
- ▶ Give advance notice of changes in routine (e.g., field trips, outside speakers, etc.)
- ▶ To help with initiating peer interactions use language such as “__ needs someone to help with a puzzle. Why don’t we join her?”
- ▶ Weekly communication from the teacher
- ▶ Don’t call out the child’s name or draw unnecessary attention to the child. If you are happy with something the child is doing, say something generic like “I love how kids are putting away their toys”
- ▶ Be aware of child’s sensitivity to loud noises or being overwhelmed by lots of chaos
- ▶ Use words to explain how you feel, not just facial expressions and body language
- ▶ Be concrete—child often has difficulty understanding abstract language
- ▶ Quarterly meetings with all related service providers and educator
- ▶ Minimize direct questioning
- ▶ Arrange appropriate seating
- ▶ Provide one-to-one time with an educator (or speech/language pathologist, or psychologist) to play a simple, familiar board game or computer

game. The relaxed atmosphere will allow the SM child to “open up.” Then, when the child is comfortable enough to speak in this situation, add one close friend in the room with the SM child and adult. Next, increase the peers to two in the same room with the SM child and adult, etc.

- ▶ Assign an adult to be responsible for the child during all drills and emergencies; this child will not call out in the restroom for help

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Resources

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders: DSM-5. 5th ed. Arlington, VA: American Psychiatric Association

www.selectivemutismfoundation.org

www.selectivemutismcenter.org

www.selectivemutism.org

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