Research Briefing for teachers and education staff

Selective Mutism

Definition

Selective mutism (SM) is an anxiety disorder of childhood in which children speak freely to only a small number of people with whom they feel comfortable. The condition is known to begin early in life and can be transitory occurring in situations such as starting school or admission to hospital. On rare occasions it can persist throughout a child's school life. These children do not usually talk to their teachers and may also be silent with their peers although they do communicate non-verbally.

Prevalence

Most studies show a prevalence of between 2 and 8 children in 10,000, however Kopp and Gillberg (1997) found an average of 18 in 10,000. For Stirling Council with a primary school roll of around 6,500 this would mean that there would be an expectation of between 2 to 10 children with SM at any time within the authority. An Educational Psychologist is likely to meet a child with SM every five years. SM is more common in girls than boys (Kumpulainen et al., 1998; Steinhausen & Juzi, 1996) which is different from most childhood conditions which tend to have a higher male:female ratio. SM is also more prevalent in bilingual ethnic-minority families (Cline & Baldwin, 1994; Steinhausen & Juzi, 1996).

Onset

The reported age of onset is usually 3 to 5 years when children tend to move outside the home setting where increased conversation is expected and the resulting problem begins to impinge on adults (Cline & Baldwin, 1994). As a result, SM is particularly reported from nursery and school age and is seen in all social strata.

Presentation

In general children with SM may find it difficult to look at you when they are anxious, tend not to smile and can look blank or expressionless. Most find it difficult to answer to the register, say hello or goodbye, be slow to respond in any way and become more anxious under pressure to speak. Most children with SM tend to worry more than their peers and can be emotionally sensitive. Sensory difficulties can be evident such as physical sensitivity to noise, smells, touch, crowds and emotional sensitivity to the reactions of others - they may misinterpret reactions and find it difficult to express their own feelings because it is painful to do so. Physical problems such as moving stiffly or awkwardly can also be evident.

Associated Features

There is currently considerable debate as to whether selective mutism is a symptom of an anxiety disorder rather than a distinctive diagnostic syndrome (Anstendig, 1999). In two studies (Black and Uhde, 1995: Dummit et al., 1997) virtually all of the children with SM met the criteria for social phobia or avoidant anxiety. This evidence challenges previous DSM-IV and ICD-10 classifications, which place SM as a separate condition.

DSM-IV and ICD-10 also report co-occurrences with SM and depression, enuresis and encopresis, hyperactivity, tics and obsessive-compulsive features. These types of associated features are best addressed by mental health professionals such as psychiatrists and clinical psychologists in CAMHS teams who can provide advice and intervention for children with anxiety disorders.

Dow et al (1995) reported that just less than half of the children with SM who attended their clinic had mild to moderate receptive or expressive language delay and Steinhaisen and Juzi (1996) found 1/3 of 100 SM children in their study had a history of speech and language disorders. Steinhaisen and Adamek (1997) report a wide range of intelligence from above average to mild or severe learning difficulties and personality traits such as shyness, seriousness, oppositional behaviours, stubbornness, aggression, hypersensitivity, perfectionism, introverted at school and extrovert at home have been noted. Cline and Baldwin (1994) found that social isolation was a significant factor. Steinhaisen and Adamek (1997) compared the family histories of 38 children with SM to a control group with speech and language disorder. They found that SM relatives were more uncommunicative and mutism was noted amongst other family members. SM family members also had a greater range of psychiatric and speech and language disorders. MacGregor et al (1994) found a higher incidence of abuse in 18 children with SM, however, Black and Uhde (1995) found no evidence of trauma in their 30 subjects. Simons et al (1997) suggest an association between SM and chromosome 18 abnormalities and Hangerman et al (1999) suggest an association with SM and Fragile X syndrome which is a genetic condition involving changes in part of the **X** chromosome. It is the most common form of inherited intellectual disability in boys.

Maintaining Factors

Children with SM associate the expectation to socially engage or communicate with a past experience of severe anxiety and subsequently link communication outside the immediate family to unpleasant feelings such as discomfort, fear or nausea. They learn to avoid these feelings by remaining silent. Unwittingly, we can often reinforce this avoidance by behaving in ways that make silence more comfortable for the child than speech.

Possible home factors, which can maintain silence and/or delaying improvement, are little expectation or need to speak/communicate as the parent always takes the lead to spare embarrassment/anxiety/disappointment or the child is pressed to talk when clearly uncomfortable and uses silence as a reaction to strangers or to express anger. Alternatively they may have experienced a limited social life and /or modeling of social interaction and/or intense warnings about speaking to strangers and taking risks. Most often the anxiety will not have been acknowledged and ready understanding of mutism prevents the child seeing that change is possible or desirable. Often adults give love/cuddles for withdrawal rather than participation and family members may have anxiety problems themselves, which can be conveyed to child.

Possible school maintaining silence and/or delaying improvement factors are centred on making the child speak. Often silence is accepted, but only after child has ‘had a go’ at speech and rewards are in place for what the child might do, rather than what the child actually does. As a result the child feels expectation to speak e.g.. ‘Are you ready to talk to me today?’ ‘I can’t help you if you don’t tell me’, increase the anxiety, which is rarely acknowledged. Lack of response from demands to talk can cause peers to ignore a child with SM causing social relationships to break down and resulting in isolation from peers and a breakdown of trust with teachers via mixed messages and expectations.

General anxiety triggers can be the size and the familiarity of the immediate audience, being overheard by others, background noise, others watching the child, expectation of eye-contact, risk of error, expectation of response (time-pressure), need to initiate (verbal/non-verbal), amount of articulatory/physical effort/speech

volume required, linguistic complexity/sentence length, listener's knowledge of mutism, likelihood of reaction to speech and fear of consequences.

Can teachers help?

Yes, by early identification and creating the right environment.

Creating The Right Environment

Raise a shared awareness of the nature of selective mutism via teamwork, consistency and a shared understanding of the child's need to ***gradually*** face their fears in their own time. Identify and address possible maintaining factors and the pattern of behaviour related to specific anxiety triggers and modify interaction/expectations accordingly. Hide your own anxiety and stay positive while calmly acknowledging child's frustrations and disappointments ("It won't always be like this") and acknowledge need for parent/professional support.

Remove all pressure to speak and ensure that associations with communication are positive by providing the ***opportunity*** to speak, no expectation (e.g. make comments rather than ask direct questions), no cajoling, gentle persuasion, bribes or reprimands. Suggest alternative (*natural*) forms of communication until child is ready to speak, allow children to sit with and talk through their friends if this is helpful and sit beside the child rather than opposite with shared focus e.g. book/activity.

Reinforce risk-taking rather than avoidance by doing things with, rather than for, the child. Build confidence through success and acknowledgement ("look at what you did!") rather than coaxing ("come on, you can do it") and empty praise ("good boy", "clever girl"), acknowledging difficulties but play them down. Focus on a smaller task that the child ***can*** manage, building in an escape route to encourage the child to have a go, allowing them to build rapport and trust with designated adult(s). Actively supporting the child's inclusion and ensuring classmates do not interpret silence as disinterest or rudeness. Using ICT to record their voice at home and play back in school to support presenting work in front of class.

References

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Kumpulainen K., Rasanen E., Raaska, H & Somppi V. (1998) Selective mutism among second-graders in elementary school. *European Child and Adolescent Psychiatry*, 7, pp24-9

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Steinhausen H.C. & Juzi, C. (1996) Elective mutism: an analysis of 100 cases, *Journal of American Academy of Child and Adolescent Psychiatry*, 35, pp606-614.

Books

The Selective Mutism Resource Manual, Maggie Johnson and Alison Wintgens. Speechmark Publishing, 2001, ISBN 0 86388 280 3

Websites

Selective Mutism Information and Research Association (SMIRA) http://www.smira.org.uk/

DVD

Silent Children: approaches to Selective Mutism, 23 minute film made with grant from DfES, available on VHS or DVD from SMIRA