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Selective Mutism: A Childhood Anxiety Disorder

By Dr. Paul O'Connell

Selective mutism, a childhood anxiety disorder, involves the failure to speak in certain settings.

Although there are sometimes difficulties in speech articulation, children with this disorder understand spoken language and are able to speak.

It is common for children with selective mutism to speak at home but not at school. Such silence can have several negative effects. For example, selective mutism restricts social interaction with peers, delays development of oral reading skills, and hampers participation in general school activities. It is also more difficult for teachers and other professionals who work with a selectively-mute child to assess the child's skills and intellectual development.

The following are the criteria for diagnosing selective mutism, as described in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (American Psychiatric Association, 1994): 1. the child consistently fails to speak in specific social situations in which speaking is expected (e.g., school); 2. this disturbance interferes with educational or occupational achievement, or with social communications; 3. the disturbance lasts at least one month, extending beyond the first month of school; 4. the failure to speak is not due to lack of knowledge of the spoken language; 5. the disturbance can't be accounted for by a

communication disorder (e.g., stuttering), pervasive developmental disorder (e.g., autism), or psychotic disorder (e.g., schizophrenia).

Selective mutism is relatively uncommon, occurring in approximately 1 out of every 1,250 children. It is slightly more common in girls than in boys, and is usually noticed before the age of five. Other associated features include excessive shyness, fear of social embarrassment, social isolation and withdrawal, impulsivity, clinging behaviour, temper tantrums, and controlling or oppositional behaviour.

Selective mutism has been understood and treated through various approaches including psychodynamic, behavioural, group and family therapy, and pharmacological approaches.

This article briefly reviews each of these approaches and describes a multimodal treatment approach incorporating several treatment methods.

In the belief that the child may be fixated at an earlier-than appropriate stage of development, the psychodynamic approaches to selective mutism focus on the child's internal psychic conflicts. This "arrested development" is thought to be connected to an overly dependent relationship between the child and mother (or other significant caregiver). Psychodynamic treatments have

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focused on long-term play psychotherapy using drawing, writing, play, body gestures, and sounds. Although this type of treatment has resulted in gains in language, the process can be slow and treatment can be a financial and emotional strain on families.

The behavioural approach, the most common type of treatment, focuses on the disorder as a learned fear of language. The treatment, therefore, involves “unlearning” the fear, usually through systematic desensitization. This requires the child to speak in gradually increasing amounts over a variety of settings (e.g., having the child speak in therapy sessions, then at school, and then in the community). Generally, behavioural approaches rely on: 1. engaging the child, family, and school in the treatment approach (e.g., through identifying the silence as a serious problem that impedes the child’s ability to learn and make friends) and building an expectation that the child will speak; 2. establishing rapport with the child using non-verbal means such as play, imitation, and drama; 3. having the child begin speaking in response to a “verbal expectation” trial; 4. increasing and generalizing the verbalizations in the therapy setting; 5. generalizing the speaking to the school and community settings using teacher and parent involvement; 6. treating any related problems as the selective mutism diminishes; and 7. gradually terminating therapy. The family therapy approach to selective mutism looks at patterns of interaction in the family that encourage the problem. For example, anxiety and rigidity within the family are thought to be contributing factors in selective mutism. Through family therapy, the therapist introduces changes to the family system that allow the child to change. Although there is, unfortunately, little systematic research on the efficacy of family therapy, success has been reported in some cases.

The pharmacological approach to treating selective mutism has recently focused on using medications for social phobias, such as the newer SSRI medications (e.g., Prozac). Treatment with this type of medication is probably most useful if anxiety is a prominent factor in the child’s mutism. Studies indicate some promising results, although children are described as not completely symptom-free. In addition, there is no information yet on the long-term treatment of selective mutism using medications. Usually, treatment with medication is combined with other types of intervention such as a behavioural approach. A multimodal approach to understanding and treating selective mutism is likely to be most effective because it simultaneously takes into account the strengths and weaknesses of the child, family, and larger environment. The process would begin with a thorough assessment of the child and family, and the impact of the child’s selective mutism on the family and school settings. Family counselling could be provided if family dysfunction is evident. The extent to which the school can be engaged should also be determined. For example, a school with limited resources might require the therapist or an assistant to visit in order to implement the intervention. Finally, where the child displays a great deal of anxiety, pharmacological interventions could be used simultaneously with these other treatments.

Although selective mutism remains a relatively rare disorder, there are some good sources of information on the subject. One excellent resource is the book *Refusal to Speak*, by S. Spasaro and C. Schafer (Aronson Press 1999).