REFEREED ARTICLE

The Silent Response: Selective Mutism

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Abstract

Selective mutism is a disorder that can negatively impact a student's learning. It can be treated effectively if it is understood as an anxiety related condition and if it is diagnosed early. Intervention strategies can be complex and are therefore difficult for educational practitioners to implement. Simplifying intervention by addressing the anxiety of the child and then moving to video self-monitoring, fading, contingency management, and cognitive behavioural therapy can make treatment more practical. By using these select methods, educators will have an easier time addressing a difficult problem, and children will benefit substantially.

Very few have ever encountered or heard of selective mutism (SM). The prevalence of the disorder is variously reported; most agree that it affects between 0.03% and 1% (Muris et al., 2016, p. 94) of the population. Since many individuals never encounter someone who is selectively mute, understanding how the terms *selective* and *mutism* define the disorder is confusing. The terms work together to describe a phenomenon that is related to the comfort and anxiety levels of those affected. SM, in contradiction to many assumptions, is not a manifestation of oppositional behaviour, and children do not simply outgrow it. Repercussions for children with SM who do not receive intervention are profound and lifelong (Kovac & Furr, 2019). However, early intervention has been proven to be very successful. To deal effectively with SM, general treatment of anxiety through relaxation and breathing is essential. Other specific interventions are also necessary. However, many current interventions take a systematic approach, resulting in increased complexity and making application difficult (Zakszeski & DuPaul, 2017). Video modelling, as one example of a specific and focused intervention, provides an approach that is more accessible to educators and facilitates treatment to reach students, freeing them so that their voices can be heard by all around instead of only a select few.

Diagnosis and Implications of the Disorder

Understanding how selective and mutism define the disorder is confusing due to the seemingly random partial or situation-specific environments in which the child chooses to speak. The child is not completely silent, a point which the history of the disorder's name makes particularly clear. SM has been variously labeled voluntary mutism, partial mutism, situation-specific mutism, and elective mutism (Kearney, 2010). "Selective" indicates that the child speaks in some situations and not in others, based on an appraisal of the anxiety the situation causes. However, because the child will talk in various familiar environments, many pediatricians unfamiliar with the disorder pronounce that the child is just shy, predicting that they will grow out of it (Kovac & Furr, 2019). There is an assumption that speech in some situations will transfer to others as the child continues to develop. However, such a prognosis is incorrect because the underlying reason for the mutism is not that the child is shy but that the child feels heightened anxiety in certain situations where speech is required (Capozzi et al., 2018). If this anxiety is not addressed directly, the child may have difficulty communicating for the remainder of their life (Arigliani et al., 2020). To avoid confusion, selective mutism must be understood as an anxiety-related disorder in which speech occurs at certain times and not others.

SM is not shyness and in contradiction to many assumptions, neither is it a manifestation of oppositional behaviour. Some educators may misinterpret a lack of speech in the classroom as

defiance or stubbornness. Accordingly, they may use behavioural strategies that demand or require speech and so unintentionally humiliate the child in class (Bergman, 2013). These strategies would have the reverse of the desired effect on students with SM by increasing anxiety. The result would be a resistance to speaking at all. The solution being offered here will not work and is not recommended. It is based on a fundamental misunderstanding of the underlying cause of SM as opposition rather than anxiety (Arigliani et al., 2020). A false conclusion that the child with SM has an oppositional nature leads to an entrenching of the disorder and not its treatment.

While most perceive not treating this disorder as having little negative effect, the repercussions for children with SM who do not receive intervention are profound and lifelong (Kovac & Furr, 2019). The time of diagnosis, usually between 5 and 8 years of age, falls within a period of significant verbal and linguistic development in the life of a child. Since verbal communication is tantamount to literacy and social skill acquisition, absence of speech can create significant deficits on academic, social, and personal levels (Bork & Bennett, 2020). Also, the quality of instruction in a classroom setting will be significantly hampered if a child cannot ask questions or interact verbally with other students. This difficulty with engagement leads to lower academic outcomes and a lack of connection with the classroom in general (Zakszeski and DuPaul, 2017). Inability to communicate and the anxiety that comes from it can also lead to depression (Arigliani et al., 2020). Lack of intervention does not simply mean that the student sits silently in class; rather, it can lead to possible lifelong impairment.

Anxiety

Preventing lifelong difficulties means addressing the underlying cause of SM: anxiety. Chemically, in children with SM, increased levels of salivary cortisol reactivity have demonstrated an activation and response in the hypothalamic-pituitary-adrenal system which indicates heightened anxiety (Poole et al., 2020). Thus, understanding the treatment of anxiety is important in targeting the root cause of SM (Muris et al., 2016). However, even though the literature has demonstrated a clear relationship between SM and anxiety, little is expressed on methods to alleviate this underlying anxiety apart from the specifics of word creation in distinctive environments. Christopher Kearney (2010) is a notable exception and addresses general anxiety directly. He provides instruction in breathing and relaxation training, which have been shown to reduce anxiety in children.

Breathing exercises reduce shallow or quick breathing when someone with SM is anxious and normalize it, thereby helping speech production. Having children with SM practise breathing exercises three times a day in anxious situations helps in alleviating anxiety and prepares the child for speech production in these environments (Kearney, 2010). Another method to ease anxiety is progressive muscle relaxation. In this technique, the child tenses and releases different muscles in the body in order to reach a state of relaxation (Kearney, 2010). Teaching children to use these methods any time they feel anxious is important. Starting therapy sessions regularly with one of these exercises is important, since anxiety should be reduced as much as possible before other treatments are introduced.

Complexity of Treatments

Beyond addressing basic anxiety, specific treatment of SM is necessary but very complex (Kearney, 2010). Treatments typically involve a combination of cognitive restructuring, contingency management, defocused communication, goal setting, hierarchical exposure, modelling, priming, prompting, role-playing, shaping, social skills training, and stimulus fading (Zakszeski & DuPaul, 2017). With so many methods available, typical teachers or counsellors must make a significant time investment to familiarize themselves with these intervention strategies. Further, this intensive treatment endeavor requires co-ordination of numerous

personnel: parents, teachers, counsellors, vice principals, educational assistants, and others. Together, these professionals must be educated on how each can play a role, agree on the treatment methods to be used, and coordinate the implementation collaboratively (Zakszeski & DuPaul, 2017). Finally, the time commitment involved can extend from several months to a year (Bork & Bennet, 2020), posing organizational and fiscal challenges. Treatment for SM seems daunting due to the complexity involved yet, if the implications for the life of the student are considered, perhaps these barriers could be overcome.

Simplifying Interventions

Removing the complexity of SM treatment involves educating those involved in a few methods, particularly those methods that have demonstrated the most effective outcomes for students. By alleviating the burden related to mastering so many approaches, teachers will have more time to focus on what is necessary and so eliminate much of the time investment in researching every possible method that might be used in treatment. Also, by simplifying the approach, administration, counsellors, and teachers will be better equipped to coordinate their efforts. Poling Bork and Sheila Bennett (2020) are aware of the above need for consolidation of treatment options. Given this, they present video self-modelling, an approach that also incorporates fading and reinforcement (contingency management), as most effective. Their research indicates that effective treatment could take place in as little as eight weeks. Consolidating options, educating staff, and constraining treatment time maybe resolve many problems educators face in dealing with SM.

Video Self-Modelling

Video self-modelling (VSM) involves recording the child speaking to a trusted adult in an empty classroom (the student's home room) with a parent. In other words, the student is recorded producing speech in a low anxiety situation. The child is read a list of questions from a script by the trusted adult and answers each question in the order presented. The video is then edited, and the teacher replaces the trusted adult in the position of asking the questions. In this edited scenario, viewers perceive the child with SM as responding to the teacher in the classroom. Through viewing themselves corresponding with the teacher, the children become desensitized to the idea of speaking with the teacher. They become more comfortable with the recognition that they can do so (Bork & Bennett, 2020). Subsequent to this, students with SM move beyond recognition through the use of fading.

Fading

Fading involves "desensitizing the child of his or her feared stimulus (e.g. speaking to a teacher/peer) by gradually exposing the child to the stimulus until it no longer poses a threat to the child" (Bork & Bennett, 2020, p. 448). Other authors call it exposure-based practice (Kearney, 2010). It is based on an accumulation of information that ranks the child's anxieties and fears based on a hierarchical scale ranging from one (being very comfortable) to ten (being very anxious or afraid). Once the list is compiled, slow steps are constructed so that the learner can become comfortable in new and more difficult situations. The teacher and the child move down the list until the child becomes comfortable in even their most challenging situations. In video self-monitoring, the child is comfortable with a parent in the classroom alone. The child then becomes comfortable watching the video of them interacting with the teacher in the classroom with the parent. Another example of fading is having the parent and child play Guess Who in the empty classroom. After the child is comfortable playing with the parent, the teacher is introduced to the periphery of the room. Eventually, the teacher comes into proximity with the game and starts making statements related to the game. These statements are not directed to

the child but take the form of general comments such as the following: “Maybe it is . . .” or “I wonder who is left?” At this point, eye contact is avoided (Bork & Bennett, 2020). This approach is called defocused communication, and it reduces the anxiety of the child since they do not feel compelled to answer (Oerbeck et al., 2018). Eventually, the child feels comfortable responding to the comments of the teacher. To make the treatment even more effective, researchers have also added contingency management to reward and reinforce positive behaviour.

Contingency Management

Contingency management is based on the behaviourist idea that rewards motivate positive behaviour. In Bork and Bennet’s (2020) example of VSM, children were asked to watch the video. Each time a child viewed their own response to the teacher within the edited video, the video was paused, and the child was invited to select a reward. After the child became comfortable with this process, a mystery reward concealed in an envelope on top of the teacher’s desk was revealed. To receive this mystery reward, the child would need to ask for it in front of the parent and classmates. Moving forward, rewards should be given in relation to speaking and encouraging a SM student, but one needs to consider the situations in which the speech happen. Rewards must consider the volume of the speech, the setting of the speech, and the extent of the speech (number of words uttered). Intervenors should encourage an increase in the volume of speech, variety of settings in which speech occurs, and length of sentences (Kearney, 2010). Rewards can be chosen by the child to keep the child highly motivated, but educators must never reward a child if the behaviour is not exhibited. Additionally, educators must maintain and communicate very clear expectations if contingency management is to be effective in coordination with the other techniques.

Fading and contingency management were added to VSM so that the desired results will be lasting and the onset of speech quick. The longitudinal nature of this intervention must still be studied; the trial discussed here included only a one-month follow up (Bork & Bennett, 2020). The only successful treatment for which longitudinal studies are available is cognitive restructuring or cognitive behavioural therapy (CBT). Some psychologists fear that contingency management training will not prove to have lasting longevity since the desired behaviour might fade as rewards fade. For this reason, they turn to changing thought patterns that influence behaviour in order to decrease the likelihood of relapse.

Cognitive Behavioural Therapy

CBT methodology focuses on addressing the underlying thoughts of the child, particularly those related to fears and anxieties. The idea is to have children slowly replace negative and nonproductive thoughts with positive ones or coping statements (Oerbeck et al., 2018). Many children with SM will have “maladaptive thoughts or worries about speaking before others” (Kearney, 2010, p. 93). The goal of CBT, usually implemented over a period of two to six months (Oerbeck et al., 2018), is to alleviate these concerns. If a child is focusing on a possible negative speech outcome such as peer laughter, the teacher or counsellor can inquire about how many times that outcome has occurred. The teacher or counsellor can then discuss what might be done if laughter were to take place. Educators should advise children with SM not to “guess” how people will react and remind them that embarrassment is temporary. Children should also be reminded that practice will result in better speech (Kearney, 2010). Alleviating fears and reminding children that they are not logical can help to restructure thought patterns that are preventing speech (Anxiety Canada, n.d.). VSM, incorporating fading, and contingency management seem highly effective in the short term for addressing SM in an educational setting, while CBT treatments can present more lasting longitudinal results.

Conclusion

Students with SM tend to sit quietly and do their work. Teachers stand by quietly misdiagnosing and misunderstanding, thinking the student is shy or displaying oppositional behaviour. Counsellors are overwhelmed with the complexity of intervention methods, and vice principals cannot justify intervention for an otherwise average student. However, students with SM no longer need to struggle by themselves or face potentially lifelong deficits. Focusing on anxiety and consolidating treatments such as VSM, fading, contingency management, and CBT can help teachers and educator teams to prepare a toolkit to intervene effectively. If properly applied, we can all begin to tell a new tale, especially those who used to struggle with SM.

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About the Author

Karl developed a strong interest in childhood education after having children of his own. "What are they learning?" "Are they learning to the best of their ability?" These questions moved him to begin a Master of Education degree where he is beginning to uncover even more questions!