

When a child won't speak

They may be “chatterboxes” at home, but kids with selective mutism don't speak at all at school. Eight questions can help you assess, and address, this disorder

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Practice recommendations

- Assess children with selective mutism for severe social anxiety (C).
- Drug therapy for anxiety and depressive conditions related to selective mutism and collaboration with school personnel and parents can help a child increase her frequency and audibility of speech in public settings (C).
- Exposure-based practices can help children with selective mutism to speak in public places (C).

on paper or drawing letters in the air. Although Lucy had passed first grade on the basis of her written work, her parents worried about her ability to succeed in second grade, where her teachers expected her to participate in class and she would need to take standardized tests that required audible verbal responses. At the urging of a school counselor, Lucy's parents took her to their family physician. They needed help in drawing her out so that the rest of the world could get to know the Lucy that they knew and loved.

Strength of recommendation (SOR)

- A Good-quality patient-oriented evidence
- B Inconsistent or limited-quality patient-oriented evidence
- C Consensus, usual practice, opinion, disease-oriented evidence, case series

Lucy's parents were having difficulty reconciling the child they knew at home with the one they sent to school. At home, the 7-year-old spoke easily with her parents and siblings. At school and in other public places such as the supermarket, mall, or park, she would not speak at all. This had been going on for several years.

While Lucy was attending school without difficulty, she seemed sullen and withdrawn to her teachers. Lucy had friends at school, but would communicate with them by writing messages

Lucy's case is typical of selective mutism

Lucy was suffering from selective mutism, the persistent failure to speak in specific social situations where speaking is expected, such as at school and with playmates.¹ Lucy's case is typical in that children with selective mutism speak well in other situations, typically at home. Thus, the disorder is not due to a communication disorder such as stuttering and it is not due to a lack of knowledge or comfort with language.

To meet diagnostic criteria, the disorder must last at least 1 month, though it can last for several years, and must interfere with a child's education or ability to communicate socially.¹

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While shy children function, those with selective mutism struggle socially, emotionally, and academically

■ A little known disorder makes national headlines

Selective mutism occurs in 0.2%–2.0% of children, affects boys and girls equally, and often begins at 3 to 6 years of age.²⁻⁹ The disorder gained national attention this past spring when it was revealed that the shooter in the Virginia Tech massacre—Seung-Hui Cho—had, as an adolescent, been diagnosed with selective mutism.¹⁰ Though his diagnosis made plenty of headlines, the disorder itself occupies little space in the pediatric literature.¹¹

What we do know is that selective mutism can have a chronic course that affects a child's ability to form friendships, complete academic tasks, develop appropriate language and social skills, and participate in standardized testing.²⁻⁹ While parents often attribute their child's behavior to shyness, this disorder goes beyond that. While shy children function, those with selective mutism struggle socially, emotionally, and academically. Children with selective mutism say the words won't come out and their body won't let them speak. One father of a 7-year-old girl with selective mutism said that his daughter "describes it as the words get stuck in her toes."¹²

Many researchers theorize that children with selective mutism have severe social anxiety, and assessment and treatment strategies are typically based on this notion. Reports in the literature have also suggested that selective mutism is related to a developmental disorder or delay, as seen in autistic spectrum disorders, as well as anxiety disorders and depression.¹³ In addition, selective mutism has been linked to oppositional defiant disorder and subtle language impairments.^{14,15}

■ Begin by excluding competing explanations

If a family is referred to you for possible selective mutism, you'll first need to exclude competing explanations for

the problem, such as hearing difficulties, speech and language disorders, school-based threats, and medical problems, such as asthma, which could prevent a child from speaking comfortably in a public setting. Assuming you are able to exclude these, and other competing explanations, you'll need to ask 8 questions of parents and school officials. The answers you get will help you to screen for selective mutism and identify key antecedents and consequences to the behavior that are important in addressing the problem.

■ 8 questions you'll need to ask

1. What specific settings involve failure to speak? Children with selective mutism typically have difficulties in school, on the playground, in malls, and at restaurants.

2. Has the mutism lasted at least one month? Brief refusal to speak is not uncommon in children.

3. Does the child speak well at home with people she knows well? Most children with selective mutism speak well at home with family members, which belies a communication disorder.

4. Is failure to speak significantly interfering with the child's academic or social development? Selective mutism must involve a significant interference in daily functioning.

5. What circumstances surround each episode of mutism? In particular, is the mutism associated with the desire to increase social attention or stimulation from others, decrease anxiety, or avoid or withdraw from adult commands or requests? A full understanding of selective mutism must include a review of triggers like these.

6. Can the child be encouraged to speak audibly in any way in certain public settings? Children with selective mutism who can speak to some extent in public situations may have a better prognosis than those who do not.⁹

7. How do others respond to, or compensate for, the child's mutism?

Do they complete tasks for the child? Order food for her? Allow whispers or communication via writing? Excessive accommodations enable a child with selective mutism to maintain the behavior.

8. Does the child appear anxious or depressed in situations involving mutism? Mutism is often linked to poor affect and social anxiety.

■ Still suspect selective mutism? Make a referral

If after asking these 8 questions you still suspect selective mutism, you will need to make a referral to a child psychologist or other mental health professional who specializes in behavioral strategies to treat selective mutism. The psychologist will meet with the child and utilize more formal methods of assessment.

The psychologist may use the Anxiety Disorders Interview Schedule for DSM-IV-TR (child and parent versions), a structured interview that emphasizes anxiety-based disorders and includes a section for selective mutism based on DSM-IV-TR criteria.¹⁶ Another helpful tool is the Functional Diagnostic Profile for Selective Mutism, which helps to assess contextual factors that surround refusal to speak.¹⁷ The challenge, of course, in conducting these interviews is that many children will not answer the psychologist's questions verbally, but may communicate via nonverbal gestures, writing, or other creative ways such as drawing letters in the air.

■ Parent and teacher logs provide valuable insight

Ongoing behavioral observations or daily logbooks completed by parents and teachers are also important in treating a child with selective mutism. If parents aren't doing so already at the suggestion of the therapist, ask them to keep a logbook and encourage them to ask the

child's teachers to keep one, as well. This log should include the number and volume of words spoken, to whom the child has spoken, where the child spoke, how others reacted (ie, Did they pay extra attention to the child?), and the child's compensatory behaviors such as whispering, pointing, crying, nodding, or frowning.¹⁸ Parents and teachers should also note the antecedents to mutism, including demands (or requests) from others, or the presence of unfamiliar people.

■ A focus on systematic desensitization

Much of the literature regarding the treatment of selective mutism consists of case reports and small-scale studies.¹⁹ The paucity of data is, in part, a reflection of the rarity of the problem as well as a historical lack of consensus among researchers about the nature and diagnostic criteria for selective mutism.

The studies we do have on selective mutism indicate that behavior modification can be effective for these patients. Behavioral treatment primarily involves child- and parent-based practices.²⁰

Child-based practices include management of physical sensations of anxiety often via relaxation training and breathing retraining. Neither technique requires verbal input from a child. In addition, the therapist will have the child practice audible words in progressively more difficult settings via systematic desensitization. These settings often include the following, in order: the child's home (with the therapist), the therapist's office, community settings such as a mall or a restaurant, and finally, school.

In these settings, the therapist might, for example, encourage the patient to:

- speak on the telephone or answer the door at home.
- stay at the therapist's office until at least one word is audibly spoken. (One approach that the therapist may use to increase rapport and

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provide opportunities to prompt speech is to play games with the child.)

- order her own food at a local restaurant.
- read a story aloud to classmates at school.

In addition to systematic desensitization, the therapist may use audio or videotapes to help the youngster. In one scenario, the therapist may ask the parents to bring in an audiotape or videotape of the child at home when she is speaking. The therapist then provides ample reinforcement for the child's speech by praising the child for having a beautiful voice and for making the tape. Audio and videotapes may also be used to help the child speak louder or work on her articulation.

■ Reinforce the positive, avoid "shaming"

Parent-based practices include reinforcing the child's speech in different settings, developing new and independent exposures to generalize speech, and consulting with school officials on an ongoing basis to address social and academic problems from poor use of speech.

The therapist is likely to remind the parent that positive reinforcement is key, while punishing or "shaming" the child is ineffective.¹¹ Some therapists will make use of a technique called "token economy," where the child's progress earns her colored chips that can be redeemed for a trip to a video game center, or a special treat, such as a sleep-over with a trusted friend.¹¹

With the therapist's help, parents can also model appropriate social interactions for a child with selective mutism because social skills may not be sufficiently developed. For example, the parent might encourage the child to answer the door or telephone. The parent might also monitor the child's interactions with friends and provide

feedback. In addition, the therapist may encourage the parents to ignore inappropriate compensatory behaviors as treatment progresses. Instead, a child with selective mutism may be increasingly challenged to provide audible speech to make requests or otherwise communicate.²¹

■ Drug therapy may include MAOIs and SSRIs

Medical treatment for selective mutism may include monoamine oxidase inhibitors (MAOIs) such as phenelzine (30–60 mg/day) or selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine (10–60 mg/day), sertraline (100 mg/day), fluvoxamine (50–100 mg/day), citalopram (20–40 mg/day), or paroxetine (5 mg/day).²² However, no large-scale studies of pharmacotherapy for selective mutism have been conducted and medication effects are quite variable. The literature in this area has consisted largely of case studies.

After 9 months of treatment, Lucy speaks up at school

Lucy's therapist (JLV) utilized many of the behavioral procedures described in this article. Treatment included exposure-based practices at home, in a clinic, in various community settings, and at school. By the end of her 9 months of treatment, Lucy was speaking independently to her classmates and teachers, though ongoing praise by her teachers was needed to encourage her to maintain an appropriate speech volume.

The literature on selective mutism suggests Lucy's case was not unusual; it typically takes several months for these young patients to improve. Ongoing communication issues, though, often linger.⁹ ■

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Punishing or "shaming" the child with selective mutism is ineffective

8 questions to ask when you suspect selective mutism

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4. Is failure to speak significantly interfering with the child's academic or social development?
5. What circumstances surround each episode of mutism?
6. Can the child be encouraged to speak audibly in any way in certain public settings?
7. How do others respond to, or compensate for, the child's mutism?
8. Does the child appear anxious or depressed in situations involving mutism?

Disclosure

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