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Understanding and treating selective mutism in children: a guide for counselors

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Abstract
Selective mutism is a clinical disorder in which a child remains silent in chosen situations despite the ability for speech. Though there are cases of selective mutism in adults, the major population in which this disorder is diagnosed is in children. This paper will focus on these children who meet the criteria for a diagnosis of selective mutism.

There are three major theoretical schools of thought regarding selective mutism. The first deals with hostility and control; the second, anxiety and social phobia; and the third, family communication in regard to the onset and maintenance of this disorder. This paper explores the causes of selective mutism from each of these perspectives.
UNDERSTANDING AND TREATING SELECTIVE MUTISM IN CHILDREN:
A GUIDE FOR COUNSELORS

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"Like a camera, the silent patient sees, hears, records, and retains everything, but does not respond verbally" (Hadley, 1994, p. 2).

Elective mutism is a specific clinical entity initially described by Kussmaul in 1877 and named by Tramer in 1934 (Krohn, Weckstein, & Wright, 1992). Historically, the term elective mutism had been used interchangeably with selective mutism (Watson & Kramer, 1992). However, since the early 1990s, selective mutism has been adopted as the appropriate term.

According to Cline and Baldwin (1994), the term selective mutism seems to capture the key features of the disorder most clearly: it is selective, being a chosen behavior by the child, and it involves a significant lack of speech where speech is normally found. Due to this trend, and the fact that current diagnosis within Diagnostic and Statistical Manual of Mental Health - Fourth Edition (DSM-IV) uses this descriptive term, this paper will also use the term selective mutism to describe this disorder.

Selective mutism is a clinical disorder in which a child remains silent in chosen situations despite the ability for speech (Cline & Baldwin, 1994; Van der Smissen, 1994). In order to be diagnosed a selective mute, the following diagnostic criteria must be met in the DSM-IV:
A. Consistent failure to speak in specific social situations despite speaking in other situations.

B. Interferes with educational or occupational achievement or with social communication.

C. The duration of the disturbance is at least one month.

D. The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation.

E. The disturbance is not better accounted for by a Communication Disorder and does not occur exclusive during the course of a pervasive Development Disorder, Schizophrenia, or other Psychotic Disorder. (APA, 1994, p. 115)

It is worth noting that this disorder is found in the DSM-IV classification, "Disorders usually first diagnosed in Infancy, Childhood, or Adolescence" (APA, 1994). Though there are cases of selective mutism in adults, the major population in which this disorder is diagnosed is in children. The remainder of this paper will focus on these children who meet the criteria for a diagnosis of selective mutism.

Selective mutism is a disorder that occurs in less than 1% of all mental health referrals (Powell & Dalley, 1995). The average age of onset of this disorder is 3 to 7 years (Cline & Baldwin, 1994; Powell & Dalley, 1995). Cline
and Baldwin (1994) also reported that selective mutism is found more frequently among girls. Though a child may be exhibiting selective mutism behaviors at an early age, the disturbance may not come to clinical attention until entry into school (DSM-IV, 1994). The average age of referral and diagnosis has consistently been found to be between 6 and 7 years of age (Krohn, Weckstein, & Wright, 1992).

A selective mute learns how to communicate without using verbal means. Most children displaying this disorder communicate nonverbally using signs or gestures, and most talk to their parents (Powell & Dalley, 1995). Children with this disorder may communicate by nodding or shaking the head, pulling or pushing, or by monosyllabic, short, or monotone utterances, or in altered voice (DSM-IV, 1994). Atlas (1993) reported that symbol use is also a means of communication for selective mutes. It can be concluded that selective mutes create a variety of ways of expressing themselves, though speech is not incorporated.

Presently, therapists, and psychologists have yet to agree as to the actual causes of selective mutism. There are many competing theories as to the reasons by which children become selective mutes. On one end of the spectrum researchers such as Krohn, Weckstein, and Wright (1995) believed that selective
mutism is a behavior in which the purpose is to control others. In opposition to this belief, Cline and Baldwin (1994) believed emotional difficulty experienced by the child is the cause of the disorder. Thus, he or she is incapacitated by emotional forces beyond his or her control. These two schools of thought, power and control versus emotional freezing, appear to be on opposite ends of the spectrum. Which should be considered correct? The exploration of that question is the crux of this paper. Understanding the etiology of this disorder will help therapists develop a framework for diagnosing and treating selective mutism.

In reviewing the literature, there appears to exist a large etiological spectrum of theories concerning this disorder. There are three major theoretical schools of thought regarding selective mutism. The first deals with hostility and control; the second, anxiety and social phobia; and the third, family communication in regard to the onset and maintenance of this disorder. This paper explores the causes of selective mutism from each of these perspectives.

Etiological Spectrum

In order to understand selective mutism, a therapist needs to have a conceptual framework in which to place the puzzle pieces of the client. Having a belief as to the reasons selective mutism occurs allows for a foundation for successful intervention.
Seven theories will be briefly discussed; however, only two will be highlighted. The two perspectives receiving the most attention will be the Social Phobia Theory and the Family Communications Model. These two perspectives were the two most often discussed in the literature.

**Hostility/Control Theories**

**Hostility theory.** At the crux of the Hostility theory is the idea that silence is used as a control mechanism by the child. Hostility is a motivating force; a conscious or unconscious impulse, tendency, intent, or reaction - aimed at injuring or destroying some object, animate or inanimate and often is accompanied by some shade of the feeling of anger and hate (Saul, 1980). Though this idea is not new, the pattern that this type of behavior creates is one that is often complex and difficult to break. The reason it is difficult break this type of patterned behavior is because the chief sources of the hostility are varied.

Saul reported that there are five chief sources of hostility: “1) Persistent and excessive childish dependence, 2) Insatiable needs to be loved, 3) Extreme demands for prestige motivated by dependency and rivalry, 4) A disordered conscience, and 5) Revenge for hostile or misguided treatment during childhood” (1980, p. 192). The use of silence is the child's weapon against the elements in his or her life that are considered stressful by the child. The discomfort experienced
by others as a result of the use of silence may reinforce the use of prolonged silence in the child and may become a preferred mode of expressing hostility (Hadley, 1994).

Attention getting - manipulative theory. Reed, Wilkens, and Hayden (1994) believed that the function of selective mutism in the child is an attempt to control others. The behaviors described by this theory are used by the child to get the response that he or she desires - primarily attention. This theory paints the portrait of a selectively mute child who is shy, timid, anxious, socially withdrawn, oppositional, controlling, having unpleasant temperament, and being a poor school performer (Krohn, Weckstein, & Wright, 1992; Powell & Dalley, 1995; Wright, Cuccaro, Leonhardt, & Kendall, 1995). These characteristics underlie the overall negativism the child displays. Associated features, such as enuresis and/or encopresis, which are also behaviors believed to be motivated by power and control issues, are present in some selective mutes, reiterating the notion that power and control are the key issues.

Anxiety/Social Phobia Theory

Social phobia theory. According to Black and Uhde (1995), selective mutism may be a symptom of social anxiety rather than a distinct diagnostic syndrome. It has been found that social anxiety severity is positively correlated
with mutism severity (Uhde & Black, 1995). This means that the greater the anxiety the more likely mutism may occur. This argument is shared by several other researchers. Powell and Dalley (1995) reported that the nonverbal behaviors involved in selective mutism have been linked to anxiety and fear and can be viewed as a developmental variant of social phobia. Wright, Cuccaro, Leonhardt, and Kendall (1995) agreed with Powell and Dalley, viewing selective mutism as a variant of social phobia, more specifically panic disorder and separation anxiety disorder. Jacobsen (1995) also referred to selective mutism as a childhood anxiety disorder because anxiety is viewed to be the behavior displayed by the child as a result of his or her life stressors. From the literature that was reviewed regarding the social phobia theory it is clear that there are two arguments that are being focused on at this time in research arenas: stress symptomatology vs. diagnosis.

**Fear reducing theory.** This theory, like social phobia theory, contends that selective mutism is a product of excessive anxiety (Hadley, 1994). The mutism carried out by the child is a form of speech blocking which then continues to exacerbate the anxiety the child experiences. The major aims of treatment is to change the valence of speech from anxiety production to anxiety reduction (Hadley, 1994).
**Self control theory.** The Self Control Theory is based on the operant conditioning model. The crux of the operant conditioning model is the elimination of a response as a function of the environmental contingencies of reward and punishment (Neale, 1994). The core control construct of the control theory model is the self (Ziller, 1990). According to this theory, the child uses silence as a self-controlling response to inhibit inappropriate verbalizations, for example, yelling out or saying obscenities (Hadley, 1994). This schema represents a system of personal postulates, principles, and rules that organize and regulate behavior within a given environment (Ziller, 1990). Therefore, the child avoids risks and adheres to the rule by using silence as a self-controlling response.

**Family Perspective**

**Family models of communication observational learning model.** The central idea behind this theory is the idea of role-playing. This theory contends that the child learns vicariously from other family members appropriate ways of expressing him or herself. According to this theory the family has minimal confidence in society and therefore insulates itself from contacts with people outside the family (Hadley, 1994).

To create an impermeable wall around the family, "secrets" are sometimes
used. Secrets are kept for a variety of reasons. The function of secrets involve bonding, evaluation, maintenance, privacy, defense, or communication problems (Vangelisti, 1994). The family secrets perspective contends that because the adult family members express exaggerated concern over revealing “family secrets” and of saying “the wrong thing,” the selective mute child chooses to only speak in the family constructs (Hadley, 1994). The fear of saying “the wrong thing” far outweighs the possibility of talking with others and revealing the family secret. Possible family secrets could be adoptions, extra marital affairs, or individual problems effecting specific family members, such as, bulimia or homosexuality.

The problem with family secrets is that they distort and mystify communication processes (Imber-Black, 1993). This process is often too complex for a child to handle, therefore the child creates a way of coping with the stress that is created by the lack of communication between the family members. This stress can be dealt with not only by becoming “mute,” but “deaf” and “blind” (Imber-Black, 1993). In other words, the child may create symptomatology that exempts him or her from having to communicate his or her feelings or thoughts to others.

It is important to note, however, that all secrets are not harmful. The ability to keep things secret is an essential power that all human beings possess in
order to protect themselves (Bradshaw, 1995). Having secrets and keeping secrets is not always unhealthy. Problems arise when the content of the secret pertains to harmful or hurtful acts and is shared by only select individuals in the family. The elements that determine the type of secret, be it positive or negative, are (a) the content - any fact, feeling, or behavior, and (b) the location - who "owns" the secret (Bradshaw, 1995). These two factors shape families and how the family members will experience the secrets.

According to Imber-Black (1993), family secrets fall into various categories. She wrote that there are positive, toxic, and dangerous secrets. Positive secrets are those secrets that are shared during holidays and special events such as, birthdays, or during a couple's intimate moments. Positive secrets are temporary secrets and are usually not harmful. An example would be not sharing what one has bought another for a gift. Toxic secrets, on the other hand, are long-standing and can ruin relationships. Most often toxic secrets are about events that occurred in the past, but currently effect the relationship in the family. Dangerous secrets, the last category, are secrets that indicate harm being done to someone, for example, abuse, rape, or molestation.

Another crucial aspect of this model is the idea of dysfunctional family rules. The number one family rule often discourages openness. It is believed that
the selectively mute child is the family's silent spokesperson for their distrust of others. Trying to maintain a family secret is difficult. Secrets create dyads, triangles, hidden alliances, splits, cut-offs, boundaries of who is “in” and who is “out,” and calibrates closeness and distance in relationship (Imber-Black, 1993). The family has to devise special “language” to keep the secret amongst “chosen” family members. This type of restricted communication not only creates a tense environment, but it teaches a child dysfunctional ways of communicating or non-communicating. The effect of family secrets for the selectively mute child reinforces a sense that it is good to stay silent with those outside the home (Cline & Baldwin, 1994).

**Mother - child relationship and the attachment theory.** The mother - child bond is one that often is looked at for elements of dysfunction. This idea is based on the attachment theory. The theory holds that the quality of the parent-infant bond guides fundamental aspects of the child’s social, intellectual, and self-esteem development by shaping how the child views the self and other people (Kendall & Hammen, 1995). According to Krohn, Weckstein, and Wright (1992), the relationship between the mother and a selective mute child is one usually described as overenmeshed, with the mother overprotecting and overindulging the child. Wright, Cuccaro, Leonhardt, and Kendall (1995) also reported that
maternal overprotection is often a contributor to this disorder. In addition to these findings marital conflict was also reported to have an effect on selective mutism (Krohn, Weckstein, & Wright 1992). Though not mentioned specifically, the father also has a role in this behavior because the father is a part of the family system.

**Application of Findings**

There are several theories that exist regarding selective mutism. It can be concluded that instead of looking toward one specific theory for all answers, a more inclusive rationale should be introduced. The combination of several of theories might give a more accurate depiction of the true causal factors of selective mutism. To be able to point one's finger at one cause is painting a falsehood in research. As with many disorders, there is no one cause, but instead the cause may be a combination of several factors, with the disorder as the culmination of these factors. A more accurate theory might contend that selective mutism is the result of three key factors: hostility and control, anxiety, and family communication.

**Intervention/Treatment**

The literature on selective mutism has one central theme, selective mutism is a rare, complex disorder that requires a multi-faceted treatment regimen.
Before reviewing the intervention discussed in the literature, it is worth noting that a number of selectively mute children eventually outgrow their mutism without intervention (Lebrun, 1990). There are situations, however, in which the effected child needs some type of treatment to overcome the disorder.

Early intervention with these children is most effective and produces a better outcome (Wright, Cuccaro, Leonhardt, & Kendall, 1995). The overwhelming consensus in the literature is that multiple treatment strategies are necessary to successfully help selectively mute children. A number of different types of treatments have been used to help children with this disorder, (e.g., individual therapy, family therapy, play therapy, behavioral approaches, a non-behavioral approach (to be explained), medication, school intervention, home intervention.) In the scope of this paper, all of the possible interventions cannot be addressed. However, the two broad approaches of behavioral and non-behavioral interventions will be discussed.

**Behavioral Treatment Plans**

The behavioral approach is most often the chosen mode of treatment for selectively mute children. This therapeutic approach assumes that human action is acquired through the learning process. Behavior therapy emphasizes the acquisition and practice of appropriate behaviors in the relevant situations.
It is believed that selective mutism is a dysfunctional way of behaving. Thus, the aim in treatment is to change that behavior which limits the child in everyday functioning. Several therapists agree that a behavioral approach provides the most noticeable change in children with this disorder (Powell & Dalley, 1995; Richburg & Cobia, 1994; Watson & Kramer, 1992).

Powell and Dalley (1995) proposed that four behavioral techniques be used in treating a selective mute: shaping, reinforcement, desensitization, and modeling. Shaping is the process of rewarding successive approximations of desired behavior, which does not require the learner to produce an entire new response pattern to receive the reinforcement. Reinforcement is the means of increasing the probability that a response will recur either by presenting a contingent positive event or by removing a negative one. Desensitization is the process in which fear responses are paired with relaxation. In doing desensitization, a series of fearful situations are presented in imagery while the person relaxes. The purpose is to reduce fear and anxiety. Modeling is learning by observing and imitating the behavior of others. Powell and Dalley (1995) believed that, if these four concepts are used throughout therapy, changes will be seen in the client.
Richburg and Cobia (1994) believed that positive reinforcement is a needed element in treatment along with contingency management and stimulus fading. As one can see, the focus in the behavioral approach is on the behavior - the lack of speech when speaking is appropriate. Thus, the focus is to model open communication, reinforce the chosen behavior, and begin steps to maintain the new behavior. If one would combine the ideas the above mentioned authors, Powell and Dalley (1995) and Richburg and Cobia (1994), postulated, a more multimodal behavioral model would be the result. Watson and Kramer (1992) did just this. The authors proposed a multimethod behavioral treatment model that uses shaping, multiple reinforces, natural consequences, stimulus fading, and mild aversives (Watson & Kramer, 1992). This culminative model provides a foundation on which a therapist could successfully build a treatment plan.

**Non-Behavioral Approach**

Though the research favors a behavioral approach in working with selective mutes, there is one major problem with this mode of treatment - it does not address the underlying problem, which could be, for example depression, grief, or anger (Hulquist, 1995). This loophole is one that is directly addressed in a non-behavioral or insight therapy.
Insight therapy assumes that behavior, emotions, and thoughts become disordered because people do not adequately understand what motivates them (Kendall & Hammen, 1995). Insight therapists try to help people discover the true reasons for behaving, feeling, and thinking as they do. The premise is that greater awareness of motivations will yield greater control over and improvement in thought, emotion, and behavior. The focus is less on changing people directly than on enhancing their understanding of their motives, fears, and conflicts.

Due to lack of empirical research, there are few valid proposals on effective non-behavioral ways to help selective mutes. Therapies such as family therapy and play therapy are ways in which some selective mutes are reached. Many therapists choose to combine these forms of therapy with behavioral approaches so the entire family can be involved. These approaches do recognize the behavior, but emphasize the total family system. This concept is key to understanding how the selective mutism evolved and how it is maintained. Getting within the family system can provide insight that strictly behavioral approaches may not appreciate. Thus, in treating the child, the family is treated as well.
Application of Findings

From the research, it can easily be concluded that many clinicians who work with selective mutes recognize that behavioral techniques work best in eliminating the problem. However, behaviorally treating the symptom without touching on the emotional root of the problem does not help the situation. A more total treatment plan should be implemented. As with the diagnosing of the problem, not one theory best fits each individual. However, if several key aspects are focused on, a more inclusive perspective can be implemented. Powell and Dalley (1995) suggested that four concepts exist in any coherent treatment strategy: learning theory treatment model, behavior techniques, play therapy, and family involvement. This treatment plan includes all of the important aspects that should be focused on in therapy. Not only is the behavior addressed, but the underlying interpersonal and interfamilial problems are worked through as well.

Case study

Following is a case study which hypothetically illustrates both symptomatology and treatment strategies.

The child in this study was a 6-year-old female enrolled in a public kindergarten class. She attended public school on a half-day basis in the afternoon and lived with her natural parents and 3-year-old sister. The child
attended a day-care program 8 months before entering public school. She reportedly stopped talking to people other than her immediate family when she started the day-care program. After the child had been in kindergarten 2 months, the child’s teacher referred her to the school’s building intervention team with the stated concern, “Does not talk to anyone except immediate family.” Thus, the child had not spoken in an educational setting for 10 months prior to school-based evaluations and treatment. It was also indicated that the child did not verbally communicate in certain environments, e.g., her peers’ homes and restaurants. This suggested that her condition could be diagnosed as selective mutism.

The child’s age, extended time, consistency, and the multiple environments in which selective mutism had been displayed were considered in determining whether treatment was warranted. Another treatment consideration was the impact that not speaking in school was having on the child’s social interactions and development. Although she was actively involved with school activities and clearly learning, she was not fully participating in all aspects of her classroom (e.g., plays, songs, and oral responses). Therefore, the inhibiting nature of the disorder was considered in deciding if treatment should be undertaken. Another important factor dictating the need for treatment was the child’s own desire to speak in school, which she articulated to her parents. Prior to and during
treatment, she repeatedly informed her parents that she wanted to talk in school.

A treatment plan was designed incorporating the child’s parents, family, and teacher. The goal of the treatment was an increase her verbalizations. To this end, several behavioral techniques including shaping, positive reinforcement, desensitization, and modeling were utilized in conjunction with play therapy and family involvement in providing her treatment.

Following treatment, the child spoke in a manner consistent with her peers. The other behavioral concerns that her parents and teacher had identified, immaturity and withdrawal, dissipated. A 6-month follow-up, completed after the child had entered first grade, indicated that she was exhibiting speaking behaviors consistent with her peers without the presence of behavioral concerns (Powell & Dalley, 1992).

The purpose of the case study is to more clearly illustrate the types of symptoms exhibited by selective mute children and explain a multi-facet treatment plan. Several aspects of this case study will be highlighted. It is first worth noting that the child in this case study had not spoken to anyone other than immediate family members for 10 months. In this time frame, other methods were used to encourage verbal communication, (e.g., rewards and consequences.) But these preliminary efforts were fruitless.
Another important aspect worth highlighting is the fact that the child verbalized to her parents that she wanted to speak in school. This communicated that she was somewhat “unable” to actually control this behavior, though it is “selective.” These two ideas contradict one another. In light of this, which theory might apply to this situation?

The last thing to be focused on is the total time limit that was needed to implement the entire treatment plan. The time limit was not specifically stated, but it can be concluded that the entire treatment process lasted for at least one academic year.

Conclusion

The etiology of selective mutism is a childhood disorder that is still being investigated. In this paper, several causal theories were explored. The idea of family secrets and family involvement was the focus of the etiology spectrum discussion. Realizing that the child is not hurting alone is the central idea of that theory. If one does believe that this is true, a more non-behavioral approach to therapy might be taken. In taking this approach the therapist will not just be treating the behavior, but working with the family system and getting to the underlying problem.
The purpose of this paper was to define selective mutism and address several aspects of selective mutism. As stated earlier, selective mutism is a rare, complex disorder that requires a multi-faceted treatment regimen. Selective mutism is a disorder that is difficult not only on the child, but on parents, and teachers.

There is hope for selective mute children. Being able to effectively work with the children and their family is difficult. However, it is possible to see positive results. The child’s silence is actually his or her loud cry for help.

It appears to this author that selective mutism is a disorder that is treatable. As stated earlier, not all selective mute children need treatment. However, if treatment is necessary, it is important to acknowledge the importance of the child’s entire support system. The literature suggests a multi-facet treatment plan. Changed behavior with the child, most importantly decreased mutism, has been the result of multi-modal treatment approaches according to studies. The purpose of this paper was to provide counselors a guide for understanding and treating selective mutism in children.
References


