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ABSTRACT

This paper reviews definitions and issues in selective mutism in children and summarizes results of interventions conducted and published since 1982. Definitions and diagnostic criteria of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (1994)" and the World Health Organization's "The ICD-10 Classification of Mental and Behavioral Disorders" (ICD-10) (1992) are provided. The paper briefly examines the following issues in definition and identification: amount of persistence necessary for diagnosis of selective mutism; relationship of selective mutism to extreme shyness; and effects of mutism on educational and social development. Twenty-seven original intervention studies are analyzed and summarized in 4 groupings: (1) behavioral treatments (9 studies, 13 children); (2) psychotherapy (8 studies, 11 children); (3) medical treatments (4 studies, 18 children); (4) mixed treatments (6 studies, 26 children). Summaries include information on sex distribution, definitions used, age distribution, types of assessment, and reported effectiveness. A summary of recommendations from the intervention studies concludes the paper. (Contains 32 references.) (DB)

Selective Mutism: Definition, Issues, and Treatment

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Two Primary Definitions of Selective Mutism

A variety of definitions appear in the literature regarding selective mutism. The essential feature of all definitions is that the individual is both capable of speech and does not speak or speaks in only a limited number of situations or to a limited number of people. Variation in the duration of the condition necessary for diagnosis and the severity of mutism are the most common differences among definitions. Two clinical guides, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American.Psychiatric.Association, 1994) and The ICD-10 Classification of Mental and Behavioral Disorders (ICD-10) (World.Health.Organization, 1992) provide definitions and descriptions of selective mutism.

DSM-IV Criteria

A. Consistent failure to speak in specific social situations (in which there is expectation for speaking, e. g., at school) despite speaking in other situations.

B. The disturbance interferes with educational or occupational achievement with social communication.

C. The duration of the disturbance is at least one month (not limited to the first month of school.

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

E. The disturbance is not better accounted for by a Communication Disorder (e.g., Stuttering) and does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder (American.Psychiatric.Association, 1994, p. 115).

The ICD-10 Definition

The ICD-10 definition (World.Health.Organization, 1992) uses the term elective mutism. This definition states:

> The condition is characterized by a marked, emotionally determined selectivity in speaking, such that the child demonstrates his or her language competence in some situations but fails to speak in other (definable) situations. Most frequently, the disorder is first manifest in early childhood; it occurs with approximately the same frequency in the two sexes, and it is usual for the mutism to be associated with marked personality features involving social anxiety, withdrawal, sensitivity, or resistance. Typically, the child speaks at home or with close friends and is mute at school or with strangers, but other patterns (including the converse) can appear (World.Health.Organization, 1992, p 278).

Features of the Definitions

* persistent refusal to speak in some but not all situations despite...
* adequate expressive and receptive language abilities which...
* persists for a substantial amount of time and...
* cannot be accounted for by other physical or emotional problems.

The essential feature is that the individual is both capable of speech and does not speak or speaks in only a limited number of situations or to a limited number of people.

Variation in the duration of the condition necessary for diagnosis and the severity of mutism are the most common differences among definitions.

Selective mutism can often be accompanied by other problems, particularly anxiety disorders and oppositional behavior; however, comorbidity with either condition is unnecessary for identification of selective mutism.

The DSM-IV definition explicitly precludes identification of selective mutism in children who lack language facility because of recent immigration to a country which uses a language different from their own.

The ICD-10 guidelines require that the child possesses adequate ability to speak and comprehend the language for social communication, thereby excluding children whose language is different from the dominant language of their environment by inference.

Issues in Definition and Identification of Selective Mutism

How much persistence is necessary for diagnosis?

Because children can have a variety of transient adjustment reactions which affect their willingness to speak, the time over which the condition is displayed can dramatically affect the number of children in which it is observed (Kolvin & Fundudis, 1981). When overly loose criteria are employed, too many children are identified with the condition, clouding the validity of the treatment and diverting resources and attention away from more severe cases by including children who, because their mutism is transient, are likely to improve without treatment or less intensive treatments than are required for selectively mute children (Cline & Baldwin, 1994).

Is Selective Mutism different from extreme shyness?

Probably the greatest distinction between these two conditions is in the situational specificity of selective mutism compared to the generality of shyness. Extremely shy children are likely to be judged as shy across situations, and individuals. Presently no clear guidelines exist to distinguish between the two conditions.

How detrimental is Selective Mutism to educational and social development?

Variations in teacher tolerance, peer group patterns of interaction and parental expectations could all be expected to influence judgments regarding the severity of impact of selective mutism on a child's development. Some selectively mute children are socially isolated and incompetent in their interactions with other individuals while other selectively mute children are able to attain social goals and avoid peer rejection through sophisticated use of nonverbal communicative behaviors such as gestures, shrugs, and head nods (Cline & Baldwin, 1994). It is unclear under what circumstances distinctions should be made between these groups of selectively mute children.

Summary Definitions and Issues

The best practices advice for identification of selective mutism in children is to consider the cluster of symptoms as a whole while remaining sensitive to other conditions (e.g., language difference, communication disorder) which could account for the behavior. Educators and other service providers along with the child's parents should weigh the benefits and risks of intervention versus doing nothing.

Approaches to Intervention

We searched the ERIC and Psyclit data bases for papers describing treatment of selective mutism. The most recent thorough review of literature we located was published in 1984 (Labbe & Williamson, 1984). We therefore limited our search to papers published from 1984 to the present. A total of 27 original intervention studies were located in this search. These studies employed treatments for Selective Mutism which were classified under four major groupings:

- Behavioral Treatments,
- Psychotherapy Treatments,
- Medical Treatments, and
- Mixed Treatments with more than one form of intervention.

Summary of Behavioral Treatments

Nine studies published 1982 - present, 13 children.

Sex	
8 male	5 female

Definition Used	
DSM (3, 3-R, 4)	3
None	2
Descriptive*	4

Ages	
4 yrs	n = 3
5 yrs	n = 2
6 yrs	n = 3
9 yrs	n = 2
11 yrs	n = 2
14 yrs	n = 1

Assessments	
"Ecological"	1
"Interviews"	1
Observation	3
Multidisciplinary	1
No Report	3

Summary of Treatments

- Reinforce speech or communicative behavior in environments where it is currently exhibited.
- Increase verbal interactions with target person in current "speech environment" then transfer target person to non-speech environment.
- Use stimulus fading to transfer speech from target individual to natural stimuli.
- Use successive approximation of speech act (e.g., move from yes/no questions to more open-ended questions).
- Extinguish non-verbal behavior which serves same function as speech (e.g., head gestures for yes and no).

* Descriptions of child's behavior but not referenced to any specific definition or guide.

Summary of Psychotherapy Treatments

Eight studies published 1982 - present, 11 children.

Sex	
? male	5 female
6 not reported	

Definition Used	
DSM (3, 3-R, 4)	4
None	2
Descriptive*	2

Ages	
4	n = 3
5	n = 2
6	n = 3
13 & over	n = 2
15	n = 1

Assessments	
"Ecological"	
"Interviews"	2
Observation	1
Multidisciplinary	3
No Report	2

Summary of Treatments

- Play therapy, individual and with siblings or classmates, transfer of play activities to non-speaking settings.
- Counseling with individual family members.
- Joint counseling sessions between parent and child.
- Family therapy focusing on mother/child dependency.
- Shift of school focus from academic goals to speaking.
- Individual therapy sessions in which the child spoke into a tape recorder for later play back.

* Descriptions of child's behavior but not referenced to any specific definition or guide.

Summary of Medical Treatments

Four studies published 1990 - present, 18 children.

Sex	
6 male	12 female

Definition Used	
DSM (3, 3-R, 4)	3
None	1

Ages	
6	n = 1
7	n = 1
12	n = 1
not reported	n = 15

Assessments	
Multidisciplinary	3
No Report	1

Summary of Treatments

- Medical treatments reviewed here operate on the premise that Selective Mutism is a manifestation of some form of depression.
- Three medications were used in these studies:
  - Desipramine
  - Fluoxetine
  - Phenalzine
- Mixed results were observed across the studies. Some children improved dramatically after medication. Most children demonstrated improvement in the home and on parent ratings but not in school or on teacher ratings.

* Descriptions of child's behavior but not referenced to any specific definition or guide.

Summary of Mixed Treatments

Six studies published 1985 - present, 26 children.

Sex	
9 male	17 female

Definition Used	
DSM (3, 3-R, 4)	1
None	2
Descriptive*	3

Ages	
3	n = 1
"average age" 4	n = 20
6	n = 1
7	n = 2
8	n = 1
16	n = 1

Assessments	
"Ecological"	
"Interviews"	2
Observation	
Multidisciplinary	2
No Report	2

Summary of Treatments

- Most mixed treatments involved some form of psychotherapeutic intervention along with :
    - Occupational therapy,
    - Behavioral reward systems
    - Dance therapy
    - Special education
- All but one study reported substantial improvement for the target child.
- No studies in this group actually reported or collected data regarding the child's speech before or after the treatment sessions.

* Descriptions of child's behavior but not referenced to any specific definition or guide.

Summary and Recommendations from Intervention Reports

When children will talk to a given "safe" person (e.g., the mother), continue this relationship and bring that individual to places where the child does not speak. Have the child converse with the safe person in the new environment and gradually fade the "safe" person from the new environment.

When children will talk in one setting but not others (e.g., the home but not school) bring a selected child or small group of children from the non-speaking environment to the speaking environment and encourage them to interact with the child. Encourage continuation of this interaction in the non-speaking environment.

Remove or extinguish the child's ability to obtain gratification through non-speech communication.

In some cases, medication may be an effective treatment along with behavioral or psychotherapeutic treatments.

Behavioral interventions appear to be most compatible with school-based treatments (i.e., teachers may be trained to implement and monitor behavioral treatments far more readily than any of the other interventions).

Enlist the support of other educators and service providers when possible.

Always obtain the support of the family when intervening with Selective Mutism.

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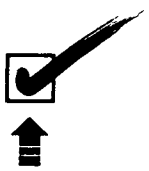

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