

Silent Suffering: Children with Selective Mutism

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Despite increasing awareness, the childhood disorder of selective mutism is under-researched and commonly misdiagnosed. The purpose of this article is to highlight current issues related to this disorder as well as describe various treatment approaches including behavioral, cognitive-behavioral, psychodynamic, family, and pharmacological interventions. Suggestions for counselors working with children with selective mutism and implications for future research are offered.

Keywords: selective mutism, childhood disorder, children, etiology, treatment approaches

Although early references occurred 125 years ago, very little has been written about selective mutism (Steinhausen, Wachter, Laimbock, & Metzke, 2006). This disorder remained relatively obscure until 2006 when *Newsday* published an article entitled “Behind a Wall of Silence” that described an eight year-old girl’s struggle with speaking at school. Selective mutism appeared in the news again the following year when it was revealed that Seung-Hui Cho, the shooter in the Virginia Tech massacre, was diagnosed with selective mutism as an adolescent (Kearney & Vecchio, 2007). Despite media coverage and growing public awareness, little research is being dedicated to examining this unique condition.

The lack of quality research and general awareness of selective mutism are serious barriers to helping children who suffer from this disorder. Too often, these children are misdiagnosed or labeled as “just shy.” Schwartz, Freedy, and Sheridan (2006) surveyed 27 parents having a total of 33 children with selective mutism. Their survey revealed that primary care physicians either misdiagnosed or never referred about 70% of these children. The authors explained: “Selective mutism has largely gone unnoticed by most physicians who are not familiar with the key signs and symptoms. Pediatricians commonly assume that the patient with selective mutism is simply exhibiting excessive shyness and reassure the parents that it is something the child will outgrow” (pp. 43–44). Within the same group of survey participants, an accurate diagnosis did not occur until an average of nearly a year after the parents expressed concerns to a medical doctor (Schwartz et al., 2006). Within school settings, labels such as autistic, language delayed, defiant, or learning disabled saddle such children with inappropriate or ineffective interventions. In many circumstances, parents simply wait for the child to “outgrow” this disorder, not realizing that the absence of proper treatment can lead to lifelong psychological problems (Shipon-Blum, 2007).

The purpose of this article is to increase awareness about selective mutism as well as provide an overview of current issues associated with this disorder. Major themes related to etiology and current trends in treatment will be addressed. The importance of early intervention and participation of family members and school personnel in the treatment process will be stressed. This article will conclude with suggestions for future research, the counseling profession, and counselor training.

Definition of Selective Mutism and Prevalence

Selective mutism is described as “persistent failure to speak in specific social situations (e.g., school, with playmates) where speaking is expected, despite speaking in other situations” (American Psychiatric Association, 2000, p. 125). Children with selective mutism often engage, interact, and communicate verbally within comfortable surroundings, such as at home or with trusted peers. These children are capable of speaking and understand their native language. However, when placed in structured social settings such as school, they are mute and socially withdrawn (American Psychiatric Association, 2000).

Social skills among children affected by selective mutism vary greatly (Amir, 2005). These children are usually unable to verbally communicate when approached by an adult, yet social interaction among peers can vary. Some

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children interact easily with peers in and outside of the home. Other children interact with peers, but do not verbally communicate with them. A third group remains completely withdrawn in social settings (Amir, 2005). Aside from verbal communication, many children with selective mutism are inhibited in other ways as well (McHolm, Cunningham, & Vanier, 2005). Avoidance of eye contact, lack of smiling, tantrums, blushing, and fidgeting are common symptoms associated with selective mutism (Dummit et al., 1997; Kristensen, 2001; Shipon-Blum, 2007).

Recent studies suggest that selective mutism may occur in .7 to 2% of early elementary students, although many researchers agree that these prevalence rates may be underrepresented due to the lack of knowledge of the disorder (Cunningham, McHolm, & Boyle, 2006; Lescano, 2008; Schwartz et al., 2006; Sharkey, McNicholas, Barry, Begley, & Ahern, 2007). Most investigators report that selective mutism seems to occur more frequently among girls (Cohan, Chavira, & Stein, 2006; Dummit et al., 1997; Lescano, 2008; Mendlowitz & Monga, 2007; Sharkey et al., 2007; Steinhausen & Juzi, 1996). Symptoms of selective mutism are usually present by the age of three, but this disorder is frequently not identified until the child enters school where there is an increased expectation to speak within social settings (Cunningham, McHolm, & Boyle, 2006; Sharkey & McNicholas, 2008). Entrance into the school environment appears to be a salient and definitive landmark for children with selective mutism.

Etiology

There is little consensus regarding the etiology of selective mutism. Psychoanalysts have cited unresolved internal conflicts as the cause of selective mutism (Cohen et al., 2006). Family systems theorists argue that children with selective mutism are part of faulty family relationships (Anstendig, 1998). Kratochwill (1981) states that behavioral therapists “have perceived mute behavior as a function of antecedent and consequent environmental events that vary across situation, people, and time” (p. 137). Early theorists argued that trauma or major life events, such as abuse or the death of a loved one, trigger the onset of selective mutism (Dow, Sonies, Scheib, Moss, & Leonard, 1995). However, according to more recent studies, children who have experienced trauma are not more likely to develop selective mutism, and early childhood trauma is rarely associated with the development of the disorder (Gray et al., 2002; Steinhausen & Juzi, 1996). In fact, Dummit et al. (1997) found no evidence of trauma among their case study participants. Therefore, isolating a single cause or traumatic event does not appear to be helpful in identifying selective mutism, thereby confusing diagnostic attempts.

Current conceptualizations of selective mutism link the disorder to anxiety, namely social phobia (Cunningham et al., 2006; McHolm et al., 2005; Sharkey & McNicholas, 2008). This particular phobia prohibits children from interacting and communicating within social settings, such as school and birthday parties. McHolm et al. (2005) explain that just as a young child can develop a fear of spiders or heights, for example, children with selective mutism have developed a fear of talking that is further crippled by anxiety.

Research has shown that anxiety disorders generally run in families. With regard to selective mutism, parents of children who have selective mutism are likely to exhibit signs of moderate to severe anxiety (Kristensen & Torgersen, 2001; Schwartz, Freedy & Sheridan, 2006; Shipon-Blum, 2007). Kristensen and Torgerson (2001) regarded selective mutism as a “family phenomenon” after they examined personality traits of parents of children with selective mutism (p. 652). According to their study, parents of selectively mute children were significantly more likely to have a history of shyness or social anxiety as compared to a control group. In a survey conducted by Schwartz et al. (2006), 33% of the participants reported a family member with social anxiety disorder and 12.1% had a family member with selective mutism. Despite the information obtained from the aforementioned case studies, it remains unclear how genetic and environmental factors affect the development of selective mutism among young children.

There also is mixed evidence concerning the association between developmental delays and selective mutism. In a study of 100 children with selective mutism (Steinhausen & Juzi, 1996), 38% of participants had a history of language delays or disorders. In contrast, other studies report no evidence of developmental delays among the participants (Black & Uhde, 1995). Definitive research in this area is lacking, and the link between developmental factors and selective mutism remains unclear.

Although the exact cause of selective mutism is unknown, researchers generally agree that selective mutism does not fall under the realm of speech/language disorders, communication disorders, defiant behavior, or shyness. In a recent

article written by Kearney and Vecchio (2007), the researchers point out that “this 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” because affected children speak well in certain situations (p. 917). A case study conducted by Schwartz et al. (2006) revealed that a very small percentage of children with this disorder have speech and/or language difficulties. Selective mutism is distinctly dissimilar from shyness due to the severity of anxiety and duration of symptoms. Shyness is not paralyzing like selective mutism and the vast majority of children who suffer from selective mutism do not fully overcome their anxiety without formal intervention (Stanley, n.d.). Finally, selective mutism has been described by some as oppositional; however this assumption implies that mutism is a conscious choice. This viewpoint is clearly disputed by recent research on this disorder (e.g., Cunningham et al., 2006; McHolm et al., 2005; Sharkey & McNicholas, 2008). Anxiety appears to be the most likely culprit at the core of this disorder. There is evidence that family history of anxiety often plays a role in the disorder while speech and language problems, along with willful opposition, do not seem to contribute to the development of selective mutism.

Approaches to Treatment

Because the etiology of selective mutism is unclear, there is much disagreement among researchers regarding effective treatment approaches. Additionally, scarce quality research has been dedicated to examining the effectiveness of individual treatment approaches and interventions. As Sharkey et al. (2007) notes: “Despite the very handicapping nature of this disorder and its negative impact on both short- and long-term functioning in children and adolescents, the evidence for effective treatments is sparse and predominantly in the form of single case reports or small series using a variety of techniques” (p. 539).

Although a systematic approach has not yet been developed, there are some common goals among varying treatment programs. An initial goal of treatment is to lower the child’s anxiety and develop healthy coping mechanisms for dealing with anxiety (Shipon-Blum, 2007). Interventions aimed at achieving this goal include relaxation skills, meditation, and breathing techniques. Increasing self-esteem and confidence in social settings is another integral objective of most treatment programs. The last and most evident goal is to increase verbal communication in social settings. As the final stage in the treatment process, increasing verbal communication may take years as well as long-term therapeutic intervention depending on factors such as the duration of the mutism and severity of symptoms.

Psychodynamic Approach

Early treatment approaches for selective mutism were mainly derived from psychodynamic theories. Interventions and techniques from this realm of therapy seemed to be the best fit as selective mutism was historically viewed as a result of unresolved inner conflicts or traumatic events during early childhood years (Kratochwill, 1981). Psychodynamic theorists describe mutism as a defense mechanism which the child utilizes rather than expressing feelings directly towards a parent, most commonly the mother (Cline & Baldwin, 1994). Through this approach, the primary goal of the counselor is not to directly address the mutism, but rather understand its origin (Cohen et al., 2006). This is accomplished by carefully examining the child’s early psychosexual stages of development as well as the mother-child relationship, then eventually addressing the fears directly with the child (Cline & Baldwin, 1994).

There exists a major pitfall in this type of therapeutic approach. Symptoms of this disorder are deeply rooted in anxiety; therefore, pressure to verbalize thoughts and feelings can overwhelm the child. While expression can be accomplished through nonverbal means such as art therapy, substantial conversation and uninhibited free association are extremely difficult to achieve. It is more likely that the child will become tense and *freeze up* when placed in the structured setting of the counselor’s office and asked to communicate. Shipon-Blum (2007) explains that psychological approaches are effective only when “all pressure for verbalization is removed and emphasis is [placed] on helping the child relax and open up” (p. 6). When pressure to verbalize is reduced, anxiety decreases and therapeutic interventions can subsequently occur.

In 1963, Browne, Wilson, and Laybourne (as cited in Garcia, Freeman, Francis, Miller, & Leonard, 2004) examined the effectiveness of psychodynamic therapy for selective mutism and concluded that the treatment was costly and commonly yielded a poor outcome. Freeman, Garcia, Miller, Dow, and Leonard (2004) added that there are no major case studies or research to provide evidence that these approaches are successful. While psychotherapy is rarely utilized as a primary

mode of treatment for selective mutism today, psychodynamic projective interventions such as play, music, and art therapy are commonly utilized by counselors in conjunction with other treatment approaches. Research has shown that these projective, less verbal interventions have been effective to some degree (Shreeve, 1991; Tatem & DelCampo, 1995).

Play therapy can offer a safe environment in which the counseling relationship is established without placing pressure on the child to speak (Hultquist, 1995). While describing the benefits of using psychotherapy with anxious children, Terr (2008) claims that effective therapy for anxiety disorders such as selective mutism “won’t truly begin until [the spirit of play] is established” (p. 101). Additionally, music therapy can assist children with selective mutism to express their thoughts or feelings via nonverbal means as well as reduce anxiety through musical expression. Amir (2005), the director of a music therapy program at an Israeli university, describes her two-year experience of working with a selectively mute child. She concluded that the therapy sessions encouraged “feelings of safety” and served as “a container and foundation where heavy feelings and emotions [could] be explored” (p. 75). Furthermore, Amir claims that a trained music therapist can interpret music created by the child in order to establish a bridge to the child’s “inner world” (p. 76). Similar to music therapy, art therapy provides a mute child with a nonverbal way to articulate feelings and fears. Cline and Baldwin (1994) noted that art therapy provides a “springboard for verbal communication” (p. 80). While these interventions are not generally used as primary modes of treatment, play, music, and art therapy can improve self-esteem and provide the counselor with an opportunity to build rapport and create a safe, inviting environment for the child.

Behavioral Approach

Researchers from the behavioral perspective view selective mutism as a learned behavior developed as a coping mechanism for anxiety. Therefore, the purpose of treatment is to decrease anxiety and increase verbal communication in settings such as school (Cohan et al., 2006). This approach incorporates practice and reinforcement for speaking in subtle and non-threatening ways. Emphasis is placed on observable behavior rather than early childhood development (McHolm et al., 2005).

Behaviorists rely on various techniques, such as shaping, self-modeling, and contingency management, to increase verbal communication and lower anxiety. Shaping, sometimes referred to as a *ritual sound approach*, is the procedure in which the counselor reinforces mouth movements and sounds that resemble speech (Mendlowitz & Monga, 2007; Shipon-Blum, 2010). This strategy involves breaking down the target goal of verbal communication into smaller steps in order to minimize anxiety. The exact sequence will vary according to the child, but some steps may include mouthing words, making sounds, whispering, repeating a word the counselor has said, and eventually increasing volume of speech (Cline & Baldwin, 1994; Lescano, 2008).

Another commonly-used strategy to elicit speech is a two-part process known as self-modeling. Using an audio or video recorder, the child speaks and answers questions within a comfortable environment. The tape is then edited to portray the child speaking in settings such as school. The child listens to the tapes repeatedly, often in the company of family members or friends, in order to become accustomed to hearing him/herself speak in these settings (Blum, Kell, & Starr, 1998). A variation of this strategy may include family members who are recorded while asking questions such as those the child might hear in school (Cline & Baldwin, 1994). The child then practices giving oral answers. Case reports (e.g., Kehle & Owen, 1990; Pigott & Gonzales, 1987) have noted successful treatment outcomes after utilizing this strategy with selectively mute clients. This technique is frequently used in many behavioral and eclectic treatment approaches, but Blum, Kell, and Starr (1998) note that taping can increase anxiety and may not be suitable for all clients.

Contingency management refers to the use of positive reinforcement as encouragement for the child to practice verbalizations. As early as the 1930’s, Skinner (1938, 1971, as cited in Neukrug, 2007, p. 101) showed that specific behaviors would be repeated if positive reinforcement were given as soon as the behavior occurred. Contingency management is often used in conjunction with systematic desensitization in which the counselor sets goals of increasing difficulty with corresponding rewards for each leveled task that is completed (Lescano, 2008). This hierarchy of tasks is created with a consideration of locations, activities, and people that affect the child’s comfort level (McHolm et al., 2005). Similar to systematic desensitization, stimulus fading is commonly used to gradually increase the number of people in the room or classroom as the child practices verbalizations. Positive reinforcement often accompanies treatments involving stimulus fading.

While psychodynamic approaches were formally the treatment of choice by many counselors and researchers, behavioral interventions are currently included in most treatment programs for selective mutism. This type of treatment provides a step-by-step approach that can be easily modified to fit the changing needs of the child. Behavioral techniques, such as shaping and self-modeling, are rarely used in isolation so it is difficult to assess the effectiveness of any single strategy. As a complete entity, behavioral treatment has been carefully researched and numerous studies have shown efficacious outcomes of this type of treatment (e.g., Gray et al., 2002; Kehle & Owen, 1990; Lescano, 2008).

Cognitive-Behavioral Approach

While the success of behavioral interventions is rarely disputed, the behavioral approach to therapy does not place emphasis on an individual's anxious thoughts. Some researchers consider this a major flaw and stress the importance of restructuring thought processes. The cognitive-behavioral approach to treatment, or CBT, is a practical, action-based treatment program that incorporates many of the aforementioned behavioral techniques such as systematic desensitization and stimulus fading. However, CBT is different from behavioral approaches because it has an additional dimension that stresses anxiety management education (Chansky, 2004). Chansky (2004) explains that during CBT, both children and parents develop "a specific set of skills to address the thoughts, physiological responses, and behaviors associated with anxiety" (p. 47). Treatment also requires children to use problem-solving and employ self-talk (McHolm et al., 2005). The ultimate goal of CBT is to help children modify their behavior by assisting them in redirecting their anxious fears and worries in healthy ways (Shipon-Blum, 2007).

Cognitive-behavioral treatment includes several components in addition to behavioral techniques. An important aspect of CBT is assessment. Many early sessions are solely dedicated to identifying factors that contribute to the child's anxiety (Chansky, 2004). The information obtained in these interviews guides treatment and provides a foundation when planning therapeutic activities. Shipon-Blum (2002), for example, has developed a continuum for ongoing assessment that ranges from non-communicative to initiating verbal communication, with many stages of nonverbal and verbal communication in between. This continuum is used to assess a child's level of anxiety within different settings as well as to set and modify goals for treatment. Since levels of anxiety are likely to elevate during behavioral interventions, particularly systematic desensitization and stimulus fading, children are taught relaxation skills in order to manage anxiety before applying such techniques (Cohan et al., 2006). These skills may include breathing techniques, muscle relaxation, or story telling (Sharkey & McNicholas, 2008).

Once research linked selective mutism to anxiety, evidence-based CBT interventions that were previously used to treat other anxiety disorders in children and adolescents were commonly incorporated in the treatment of selective mutism (Mendlowitz & Monga, 2007). One of these interventions, cognitive restructuring, has been utilized to call attention to and minimize negative or anxiety-producing automatic thoughts (Chansky, 2004). In its conventional form, this type of intervention requires the client to share and express feelings to the counselor. This clearly presents an obstacle when working with children who are selectively mute and are not comfortable talking in certain situations, such as a counselor's office (McHolm et al., 2005). If a child can be expressive using nonverbal means, or if a child is comfortable enough to speak to the counselor, cognitive restructuring can assist a child in learning to cope by thinking realistically. It is important to mention that a child's cognitive development dictates how well this intervention may work. Therefore, this intervention may be most effective with older children having average to above-average intelligence and the ability to think flexibly and in abstract ways. Despite these limitations, cognitive restructuring is an important element in the treatment process for some children.

Cognitive-behavioral treatment has gained attention from researchers of this disorder. Recent case studies and reviews (e.g., Cohan et al., 2006; Mendlowitz & Monga, 2007; Schwartz et al., 2006; Woodcock, Milic, & Johnson, 2007) have demonstrated the success of CBT in treating children suffering from selective mutism. Additionally, the safe nature of this type of treatment along with its high success rates, make it popular. Perhaps its most significant drawback is the amount of time and patience required of the counselor. Mendlowitz and Monga (2007) estimated that children suffering from selective mutism require five to six times more CBT intervention sessions than children suffering from generalized anxiety or separation anxiety.

Pharmacological Approach

Sometimes a child's symptoms are so debilitating that fully engaging in a counseling treatment program seems challenging. In such cases, researchers may initially utilize pharmacological interventions to assist the child in overcoming anxiety associated with the disorder so that other treatments can subsequently occur. This type of intervention may include selective serotonin reuptake inhibitors (SSRIs) or monoamine oxidase inhibitors (MAOIs) (Kearney & Vecchio, 2007). While pharmacotherapy is not generally recommended as the primary treatment, the use of medication can often facilitate CBT or other interventions (Kumpulainen, 2002). Once anxiety levels have been reduced via medication, verbal communication may become less challenging for the child.

The effectiveness of pharmacological interventions is perhaps one of the most widely debated issues related to this disorder. Shipon-Blum (2007) deems a combination of behavioral techniques and medication the best approach to treating selective mutism, while Black and Uhde (1995) noted that the differences between pharmacologically treated and non-treated groups were mostly insignificant. Kumpulainen (2002) reported that pharmacological interventions could be helpful when treating selectively mute children, but also warns that medication should be used in conjunction with other therapy modalities only when they are not independently successful. It is important to note that the short- and long-term effects of pharmacotherapy remain unclear. While Kumpulainen (2002) reported that participants seldom reported any harmful effects of the medication, Kearney and Vecchio (2007) admit that there are no large-scale studies of pharmacotherapy for selective mutism.

Family Counseling/Therapy

Family counseling or therapy is often a necessary component of an effective treatment plan for children with selective mutism. Meyers (1984) noted dysfunction within the families of children with selective mutism. Other studies have cited higher rates of marital conflict and divorce among families of children with selective mutism when compared to controls (Viana, Beidel, & Rabian, 2009). Researchers from the family systems perspective have hypothesized that a child's mutism serves a certain function within the family (Anstendig, 1998). Therefore, it may be beneficial for all members of the family to participate in counseling in order to resolve underlying family issues that may have maintained the mutism. In general, the goal of family intervention in relation to selective mutism is to identify faulty family relationships and communication patterns that may have contributed to the development of the child's anxiety. The counselor would subsequently aim to help family members remove conditions that are causing the child's anxiety and maintaining the mutism (Cohan et al., 2006).

While research concerning the effectiveness of family counseling is scarce, it is evident that the cooperation and participation of parents in the treatment has a positive impact on recovery (e.g., Kumpulainen, 2002; Mendlowitz & Monga, 2007; Sharkey et al., 2007). In fact, Sharkey and McNicholas (2008) deemed parental involvement as the "key ingredient in treatment success" (p. 544). Acceptance and understanding of the disorder is crucial, and parents should not place emphasis on the lack of verbal communication. Shipon-Blum (2007) emphasizes the importance of parent participation during the treatment process: "Praise should be given for the child's accomplishments and efforts, and support and acknowledgement should be given for their difficulties and frustrations" (p. 5). Treatment programs often require parents to modify their parenting styles as well as develop healthy coping skills for handling stress and fear. Anxiety management education is often integrated with treatment so that parents are equipped to model healthy coping abilities for their children (Mendlowitz & Monga, 2007).

Counselors also may encourage parents to consider the amount of attention that is given to the child's nonverbal behavior (Beidel & Turner, 1998). A child's lack of verbal responses can result in a sibling or parent consistently answering for the child or overcompensating by frequently calling attention to the child's strengths or talents. In a case study by Sharkey et al. (2008), researchers trained parents to ignore their child's mutism and reinforce verbal behaviors by consistently responding to these behaviors with empathy, enthusiasm, and warmth. Shifting attention to verbal behaviors rather than nonverbal behaviors provides positive reinforcement for such actions.

Multifaceted Approaches

Due to the complex nature of this disorder, there exists strong support for treatment programs for selective mutism to

be multifaceted, address anxiety in a variety of settings, and involve teachers, peers, parents, and other family members during the treatment process. Therefore, an eclectic approach is the most common treatment option currently used by counselors. Countless researchers have successfully combined psychodynamic, behavioral, cognitive-behavioral, pharmacological, and/or family counseling interventions. An example of a successful eclectic treatment approach was described by Wright, Cuccaro, Leonhardt, Kendall, and Anderson (1995) in a preschool-aged child. This treatment included behavioral interventions, play therapy, family therapy, and pharmacotherapy. Jackson, Allen, Boothe, Nava, and Coates (2005) also used a multifaceted approach consisting of shaping, systematic desensitization, play therapy, parent journaling, and relaxation training to successfully treat a six-year-old boy with selective mutism. While this type of treatment approach has consistently appeared to be effective in published case studies, more research is needed to reveal which components of these programs are essential.

Importance of Early Diagnosis and Intervention

Early, accurate diagnosis and intervention are crucial to overcoming selective mutism regardless of the type of treatment program. Research suggests that treatment for this disorder is most effective if it begins as soon as symptoms of the disorder become apparent, thus minimizing the amount of negative reinforcement for these behaviors (e.g., Schwartz et al., 2006; Stone & Kratochwill, 2002). Shipon-Blum (2007) explains: “The earlier a child is treated for selective mutism, the quicker the response to treatment and the better the overall prognosis. If a child remains mute for many years, his or her behavior can become a conditioned response where the child literally becomes accustomed to nonverbalization as a way of life” (p. 5).

Shipon-Blum (2007) warns that if selective mutism is left untreated, the academic, social, and emotional repercussions may include depression, social isolation, poor academic performance, self-medication with drugs and alcohol, and suicide. Furthermore, Chansky (2004) points out that untreated anxiety associated with selective mutism also can lead to adverse health effects including cardiac, immune, and respiratory problems. Thus, early intervention provides more opportunity for successful treatment and, in the long term, a healthier, more functional child.

Role of School Personnel in Treatment

School personnel, especially teachers, play crucial roles in the treatment of selective mutism. Because the symptoms of this disorder are more evident once the child begins school, teachers often become responsible for making a referral for diagnosis. Most school personnel do not have the expertise or experience to deal with this disorder single-handedly, but it is important that teachers recognize anxious tendencies among these children and solicit the help of a school psychologist or counselor in order to make prompt referrals. Once an accurate diagnosis is made, studies (e.g., Kumpulainen, 2002; Lescano, 2008; McHolm et al., 2005) have shown that the willingness of the teacher and other school personnel to collaborate with the parent(s) and counselor affects the outcome of the treatment program. A multidisciplinary team that includes the child’s teacher, principal, school counselor, and/or school psychologist may collaborate with the parent and contribute observations and feedback to the counselor (Lescano, 2008; McHolm et al., 2005). Vecchio and Kearney (2007) indicated that this team approach may be helpful in treatment “because of the widespread nature of the child’s [speech] avoidance” (p 41).

Teachers may assist in reinforcing behavioral treatment techniques as well. For example, a teacher may provide positive reinforcement for verbalizations in school or participate in a video recording which the child will use to practice formulating verbal responses to questions. The teacher also may help to minimize anxiety while the child is in school. Shipon-Blum (2003) emphasizes the importance of a caring classroom teacher who understands the behavioral characteristics of the disorder and allows the child to communicate by nonverbal means as long as necessary. A nurturing, comforting classroom environment and flexibility within the classroom setting and schedule also are important factors in a multifaceted treatment program (Shipon-Blum, 2003). Overall research, therefore, supports both an individual and systematic approach that includes school personnel for the treatment of selective mutism.

Summary and Commentary

As described in this article, selective mutism is a complex psychological disorder with an unknown origin. There is general agreement that selective mutism is characterized by a child’s inability to speak in certain social settings despite

the ability to speak in other situations. Nonetheless, there is disagreement among researchers regarding the most efficient and definitive treatment approach. Treatment has included a variety of psychodynamic, behavioral, cognitive-behavioral, pharmacological, and family systems methods. It seems that these approaches are rarely used in isolation; rather treatment programs for selective mutism are usually multifaceted. The cooperation of parents and school personnel during treatment is crucial for positive outcomes, and early intervention can minimize the long-term psychological effects (Kumpulainen, 2002; Shipon-Blum, 2007).

Suggestions for Counselors

While the main purpose of this article is to raise awareness of this disorder and its varying treatment options, counselors who are treating children with selective mutism should prioritize goals during treatment. Less emphasis should be placed on the absence of verbal communication, especially during the initial stages of counseling. An immediate goal is to build rapport and a trusting counseling relationship with the child. Once rapport is established, anxiety reduction is a vital component of any treatment plan for selective mutism. Behavioral strategies, such as stimulus fading and systematic desensitization, that are implemented before healthy coping skills are established will likely increase a child's anxiety and delay further treatment. In addition, it is important that the counselor and parent(s) work together to build the child's self-esteem and confidence, especially in social settings. Once anxiety levels are lowered and a child's confidence is established, verbal communication interventions will likely follow.

Additionally, it is vital that counselors design multifaceted therapy programs when treating children with selective mutism. Due to the complex nature of this disorder, eclectic treatment addresses varying symptoms and psychological effects caused by selective mutism. A multidisciplinary team should be established to assist the child in treatment. As discussed earlier, school personnel play an important role on this treatment team since the child's mutism is likely to be most apparent at school. These professionals may aid the counselor by providing regular monitoring of progress and implementation of behavioral interventions.

Lastly, it is important that a counselor take into consideration the amount of time and patience required to implement a treatment program for selective mutism. A thorough and detailed assessment is first required to determine factors affecting the child's mutism. Jackson et al. (2005) recognized "an in-depth analysis of the client and his or her environment" as a precursor for treatment (p. 107). After the initial stages of treatment and assessment, it is anticipated that the counselor will spend a considerable amount of time working outside of the office (Vecchio & Kearney, 2007). The counselor may conduct observations at the child's school, meet with the child's teacher and school counselor, and interact with the child in various social settings in order to effectively monitor and adjust treatment goals and implement appropriate interventions. If the counselor is unwilling or unable to devote such a level of time and dedication, a referral to another counseling professional with knowledge of this disorder should be provided to the client.

Suggestions for Future Research

Selective mutism has gained considerable national and global attention, particularly due to several magazine and professional articles recently published about this disorder. As a result, awareness is increasing while quality research on this serious disorder is scarce. Evidence for effective treatment has been predominantly presented in the form of single-case studies using a variety of techniques. Within these studies, the duration of treatment and follow-up time is brief and the age range is narrow, usually addressing only the needs of younger elementary school children (Cohan et al., 2006). In order to better understand selective mutism and the treatment approaches that best minimize its associated symptoms, it is imperative that large-scale studies are conducted with a focus on the efficacy of isolated techniques.

Beare, Torgerson, and Creviston (2008) described interventions used to increase the verbal behavior of a 12-year-old boy with selective mutism. These researchers exclusively utilized positive reinforcement to successfully increase verbalizations in three different settings. This is the only known case study where a single intervention was isolated and its effectiveness examined. It is important to note that case studies have limitations, involve a limited number of participants, and often lack control groups, as did this study. Despite such limitations, this study provides a springboard for further research on isolated interventions and will hopefully precipitate large-scale research devoted to examining effective treatment interventions for selective mutism.

In addition, research should be specifically devoted to examining the impact selective mutism has on long-term social development. It is logical to expect some level of social maladjustment regarding development of social relationships with peers given that children with selective mutism have limited social interactions. This is supported by research that has linked anxiety disorders, specifically social phobias, with social withdrawal and other difficulties regarding sociability (Beidel, Morris, & Turner, 2004). Nonetheless, case studies (e.g., Cunningham et al, 2004; Kumpulainen, 1998; Pelligrini, Bartini, & Brooks, 1999) imply that children with selective mutism are not bullied or victimized more than children who do not have selective mutism. More research is needed in this area to determine the extent of social maladjustment among children with selective mutism. Additionally, research should be devoted to investigate long-term effects of this disorder after the mutism is overcome. For example, exploring the ability to form relationships during teenage and adult years may help clarify the impact of mutism on long-term social development.

While an increasing amount of literature on selective mutism has been published during the last fifteen years, studies involving school personnel are virtually nonexistent. Children with selective mutism spend several hours each day with school professionals who are often involved in treatment interventions. More importantly, school is frequently the setting in which these children have the highest level of anxiety and mutism. Research has shown that teachers' involvement in the treatment process is vital to positive treatment outcomes (e.g., Kumpulainen, 2002; Lescano, 2008), yet their role in the treatment process is rarely described in the research. There is an urgent need to carefully examine these children's behaviors and interactions in the classroom during treatment, as well as interventions performed by the teacher. Such information would be vital to determining the overall effectiveness of treatment programs, specifically within the school setting.

Suggestions for Counselor Training

In addition to the recommendations pertaining to research and the counseling profession, it is important that counselor education provide training for treating this disorder. It is imperative that counselors, especially school counselors or counselors working with children, be trained in identifying the signs and symptoms of selective mutism. This training should stress that selective mutism be treated as an anxiety disorder, and the difference between this disorder and shyness, autism, or speech/language disorders should be emphasized. Additionally, instruction on non-verbal assessment tools should be provided as this is an ongoing aspect of treatment. Finally, counselors should be trained to work cooperatively with school personnel and parents when treating children with anxiety-related disorders, including selective mutism, because empathetic and knowledgeable school personnel are assets to successful treatment programs.

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