SELECTIVE MUTISM:

EXPLORING THE KNOWLEDGE AND NEEDS OF TEACHERS

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MALKIE DAVIDSON

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APPROVED: _____
Geraldine V. Oades-Sese, PhD

_____
Karen L. Haboush, PsyD

ACTING DEAN: _____
Cary Cherniss, PhD

ABSTRACT

Selective mutism is a disorder that is usually identified when children begin attending school. Children's symptoms may go unrecognized or untreated for several years, increasing the degree of symptomatology and negative effects on academic and social functioning. Delay in receiving intervention also contributes to the decreased effectiveness of treatment. Therefore, teachers are key in the identification of selective mutism and referral of these children for assessment and intervention. To date, no research has been found relating to teachers' knowledge and needs in teaching students with selective mutism. The purpose of this study is to gain an understanding of teachers' knowledge of and awareness about selective mutism and garner information about their experiences in teaching these children. Participants included six teachers from Kindergarten to 8th grade at New York City public schools in the borough of Manhattan. A semi-structured phone interview was conducted to determine teacher knowledge of selective mutism in order to gauge the following: gain an understanding of how selective mutism manifests in the classroom, the referral process, utilization of outside consultation, classroom interventions/strategies used by teachers and teacher needs. Responses were analyzed quantitatively and qualitatively looking for patterns in the above domains. Findings indicate that although teachers were generally supportive and innovative in helping and teaching children with selective mutism, professional development on selective mutism, as well as the documentation of the referral, assessment, and intervention processes were areas that warrant attention. To address these needs, guidelines for school psychologists were developed to aid teachers in the

identification of selective mutism and documentation and data management of applied interventions and relevant progress. The guidelines also include informational and supportive resources for school staff, parents, and students.

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Chapter 1

Introduction

Selective Mutism (SM) is a childhood disorder characterized by the absence of speech in select environments, including school, although the child has intact vocal abilities (DSM-IV TR; American Psychiatric Association, 2000). Due to a lack of national studies, reported prevalence rates vary widely from less than 1% to as high as 2% of children in the younger grades (Steinhausen, Wachter, Laimbock, & Metzke, 2006). In the most recent edition of the Diagnostic Statistical Manual Fourth Edition-Text Revision (DSM-IV-TR), selective mutism is classified within the domain of Other Disorders of Childhood. The diagnostic criteria for selective mutism include all of the following: the child does not speak in certain settings, despite speaking in other situations; this lack of speech must last one month, excluding the first month of school; and cannot be due to another problem (i.e., language, pervasive developmental disorder, schizophrenia).

The school setting is the primary context where children initially manifest characteristics of selective mutism and are identified by teachers, as pressures to speak are intensified and detrimental affects become obvious (Cohan, Chavira, & Stein, 2006). Although these children do not appear to suffer from cognitive deficits, as assessed by IQ measures (Cunningham, McHolm, Boyle, & Patel, 2004), their anxiety may significantly impact their ability to learn and concentrate (Pionek-Stone, Kratochwill, Sladezcek, & Serlin, 2002). In addition, as rated by teachers and parents, these students present with social skill deficits, in regards to assertiveness, social responsibility and social cooperation, similar to those associated with social phobia (Cunningham, McHolm,

Boyle, & Patel, 2004). As young children progress to higher grade levels, teachers are challenged with assessing the non-speaking students' academic development, especially in reading, and enforcing curriculum that requires oral presentations (Dow, Barbara, Sonies, Schieb, Moss, & Leonard, 1995; Schwartz & Shipon-Blum, 2005).

Research shows that as many as 40% of children with selective mutism are not properly diagnosed and/or referred for treatment (Black & Uhde, 1995; Dummit, Klein, Tancer, & Asche, 1997). Therefore, the incidence may be higher than reported (Ford, Sladeczef, Carson, & Kratochwill, 1998). Yet, even when children are diagnosed at a young age, there is often a lapse of four or more years before treatment is initiated (Schwartz & Shipon-Blum, 2005). This presents a real challenge for children affected with this disorder, as the longer a child remains untreated, the more crystallized behaviors associated with this disorder become, thus decreasing the efficacy of interventions (Krysanski, 2003). Pediatricians Schwartz and Shipon-Blum (2005) acknowledge that pediatric literature, which states that symptoms usually resolve after a few months, is misguided. Unfortunately, this erroneous information results in many late referrals and missed opportunities for treatment. Furthermore, there is a lack of diagnostic tools available for clinicians' use in identifying children with selective mutism.

Until very recently no statistically sound screening measures were available to assess the severity of speech inhibition across different settings in selectively mute children (Letamendi, Chavira, Hitchcock, Roesch, Shipon-Blum, & Stein, 2008). Rather, anxiety measures and behavior rating scales were often used in conjunction with the DSM-IV-TR criteria to identify a child with selective mutism. Preliminary studies have demonstrated that the Selective Mutism Questionnaire (SMQ) created by Bergman

(2008) is the first reliable and valid measure for assessing the severity of mute behaviors across different settings (Letamendi et al., 2008).

The SMQ is user-friendly, as it is easy for parents to understand and complete. However, research is lacking to determine its utility and capacity to diagnose children with selective mutism. The SMQ, however, can assess the severity of SM in children who have been already identified. Although Bergman (2008) has developed another form with questions for teachers, data has not yet been collected to assess its ability to screen children for selective mutism in the school environment - the primary setting for the manifestation and identification of this disorder.

Studies suggest that only 60% of children with this disorder receive treatment (Black & Uhde, 1995; Dummit, Klein, Tancer, & Asche, 1997), leaving the remaining untreated children impaired (Bergman et al., 2002). Therefore, it is essential that school psychologists and other personnel have resources to help properly identify, refer and respond to students with selective mutism (Sanetti & Luiselli, 2009; Schwartz & Shipon-Blum, 2005). To achieve this, guidelines and strategies related to understanding and intervening with students presenting with selective mutism in the schools are greatly needed.

Research has not yet been able to identify a particular intervention that is consistently successful in treating this complicated and persistent disorder (Krysanski, 2003; Sanetti & Luiselli, 2009; Schwartz & Shipon Blum, 2005). Rather, a multi-method behavioral approach individualized to a particular client is the best and most logical course of action (Krysanski, 2003). Anxiety reduction interventions, including behavioral, cognitive-behavioral and pharmacotherapy approaches, are currently the

preferred treatments, as they are evidence based and empirically supported (Cohan, Chavira, & Stein 2006).

Given that selective mutism is believed to be a manifestation of anxiety, the literature indicates that the goals of school-based treatments are to decrease anxiety and encourage interaction in all settings, through the use of cognitive-behavioral interventions (Krysanski, 2003). Yet, exactly how this should be executed appears contradictory in the research. On the one hand, teachers and other school members are advised to refrain from pressuring a child to talk and from overemphasizing verbal performance (Elizalde-Utnick, 2007; Krysanski, 2003; Schwartz & Shipon-Blum, 2005). Yet on the other hand, many teachers tend to eventually decrease or withdraw their requests for the student to participate or answer questions, which may serve to reinforce the mutism (Krysanski, 2003).

Currently, there are no published studies which examine teachers' knowledge of selective mutism. In addition, there are still many unanswered questions among researchers regarding the most effective interventions to treat this disorder in the school setting. Thus, it is crucial that we learn more about selective mutism as it pertains to the educational environment. This information will allow all members of the treatment team (i.e., parents, teachers, physicians, relatives) to better identify selective mutism and implement relevant strategies in the classroom.

Teacher Knowledge of Selective Mutism (Pilot-Study)

Research clearly identifies school as the ideal setting for symptom recognition and treatment, with teachers as key players. Therefore, it is troubling that many children are not properly identified within these settings. To gain a cursory understanding of

teachers' knowledge and needs in regards to teaching children with selective mutism, the researcher lead a focus group with 10 educators and school personnel that worked with elementary grade students (i.e., three special education teachers, five general education teachers, two school psychologists) during Fall 2009 at a New York City elementary public school, where this researcher is employed. Findings indicated that teachers: (a) had difficulty defining selective mutism, (b) were not clear how it differs from shy behavior, (c) had little knowledge of appropriate classroom interventions, and (d) were unable to easily access help from the school psychologist, due to time constraints. Although many of the teachers understood that these children may have underlying feelings of anxiety, a large percentage of the group incorrectly believed that selective mutism stems from traumas or oppositional behavior. From this focus group it appears that many educators seem to overlook or wrongly attribute symptoms, which, in part, is likely due to a lack of accessible resources to aid in identification. Teachers also experienced frustration from slow or minimal progress. This is a function of a lack of knowledge or assistance from others, as well as high personal expectations and difficulty juggling the needs of many diverse children. Information gleaned from this focus group assisted in the development of research questions and survey items for the teacher questionnaire used in the present study.

While one empirical parent questionnaire, the Selective Mutism Questionnaire (Bergman, 2008) exists, no such measures are available for teachers in the school setting. Thus, research is needed to explore teachers' needs and knowledge, as well as the behaviors they observe among this population so that identification and referral guidelines and strategies can be created for school personnel. It is believed that providing

teachers with identification and referral guidelines, as well as an easily accessible selective mutism screening tool, will be valuable in improving teachers' knowledge of this disorder, as well as increasing proper and timely referrals. Early identification and intervention in the school setting will likely pave the way for better treatment outcomes.

The Present Study

Teachers play a vital role in identifying and treating children with selective mutism. However, due to teachers' lack of resources, understanding, and knowledge of selective mutism, students with this disorder may be overlooked and not promptly referred. This can then result in delayed referral and identification, as well as impact future treatment initiation and treatment outcomes. Therefore, the purpose of this study is to investigate teachers' understanding and knowledge of selective mutism, in terms of the referral/identification process and use of classroom strategies, as well as to explore the needs of teachers in educating these students. The goal of this study is to develop identification and consultation strategies for school personnel (i.e., school psychologists and teachers), especially those in the New York City Department of Education, where the study is being conducted. Data gathered in this study will also serve as a spring board to develop a screening instrument and school/teacher training program in the future.

The present study addresses the following research questions:

1) What do teachers know about selective mutism in terms of symptomatology and etiology?

2) What do teachers report regarding the presentation of students with selective mutism in the classroom?

3) What is the referral process for this sample? For example, who refers these students to whom and what is the average time span from identification of the problem to diagnosis of selective mutism?

4) Once children are identified, what strategies do teachers use, if any? How do they measure or know that these strategies are working? Where or from whom do teachers learn these strategies (e.g., School Psychologists, Web)?

5) What are the challenges that teachers face, both personally and professionally in terms of teaching a child with selective mutism (e.g., lack of support, difficulty assessing student's academic skills)? How do teachers respond to these challenges? What resources would benefit teachers in understanding, teaching and intervening with these students (e.g., training, consultation)?

This is the first study to explore teacher knowledge and needs when teaching a student with selective mutism. Findings of the survey will help the researcher develop guidelines and supporting materials to be used by both teachers and school psychologists in terms of identification of the disorder, consultation, home school collaboration and data collection. Given that this disorder primarily manifests in the class setting, research and resources that address teacher and classroom needs are crucial to best educate and service children with selective mutism.

Chapter 2

Literature Review on Selective Mutism

History of Selective Mutism

In the late 19th century, Adolf Kussmaul first recognized symptoms in which children did not speak in some settings, in spite of intact speech abilities. Kussmaul coined this disorder "Aphasia Voluntaria." Tramer, an English physician, renamed this disorder "Elective Mutism" in the early 1930's. Only in 1994, when the Diagnostic Statistical Manual, Fourth Edition (DSM-IV) was published, did this disorder receive its current name of selective mutism, reflecting a changed perspective on this condition. Selective mutism was previously believed to stem from control or oppositional behavior where the client chose or elected not to speak. However, the disorder is presently conceptualized with an anxiety component that inhibits the child from speaking in some situations (Dow, Barbara, Sonies, Scheib, & Moss, 1995). Fairly uncommon and newly recognized, selective mutism has only been explored and researched in the professional literature for about two decades, resulting in a dearth of information on the etiology, course and most effective interventions (Cohan, Chavira, & Stein, 2006).

Diagnostic Criteria

According to the Diagnostic Statistical Manual, Fourth Edition, Text Revision (DSM-IV TR; American Psychiatric Association, 2000), the diagnostic criteria for selective mutism include the following: (a) the child does not speak in certain settings, despite speaking in other situations; (b) lack of speech must last one month, excluding the first month of school; and (c) lack of speech cannot be due to another problem (i.e., language, pervasive developmental disorder, schizophrenia). Associated behaviors of

selective mutism as outlined in the DSM-IV TR include, “excessive shyness, fear of social embarrassment, social isolation and withdrawal, clinging and compulsive traits, negativism, temper tantrums, or controlling or oppositional behavior, particularly at home (American Psychiatric Association, 2000, p. 126).”

Classification of Selective Mutism in the DSM-IV-TR

There is much discussion in the literature questioning the accuracy of clustering selective mutism together with childhood disorders, rather than with anxiety disorders (Black & Uhde, 1992; Dow et al., 1995; Dummit, Klein, Tancer, & Asche, 1997; Yeganeh, Beidel, Turner, Pina, & Silverman, 2003). Empirical evidence demonstrates an increased rate of psychiatric disorders, mostly phobic disorders, for those with selective mutism, supporting selective mutism as a subcategory of anxiety. Regardless of the classification, it appears that selective mutism is more complex and multidimensional than the traditional symptoms and diagnostic criteria outlined in the DSM-IV TR suggest (Steinhausen, Wachter, Laimbock, & Metzke, 2006).

Prevalence

Due to a lack of sufficient national or international epidemiological data (Bergman, Piacentini, & McCrackem, 2002; Cohan, Chavira & Stein, 2006; Sanetti & Luiselli, 2009) and changing diagnostic criteria in recent versions of the DSM (Bergman et al., 2002), much variability exists in the literature regarding the reported prevalence of this disorder, with a range of .08 to 2% of the general population (Steinhausen et al., 2006). Although most research in the last decade reports less than 1% prevalence rate (Bergman et al., 2002; Ford, Sladeczef, Carson, & Kratochwill, 1998), some believe that these statistics are indeed underestimated. Family and educators often do not intervene or

refer these children, since parents may not be alerted to issues primarily occurring at school or teachers may be unaware of the need to refer (Ford et al., 1998). Based on a community sample which demonstrates .71% prevalence rate, Bergman and colleagues (2002) postulated, that selective mutism is equally prevalent compared to other childhood disorders such as obsessive compulsive disorder and depression, and is even more common than autism. Furthermore, one recent investigation demonstrated the occurrence of selective mutism with a frequency as high as 2% for second graders (Cunningham, McHolm, Boyle, & Patel, 2004). Although there is much variability as to the prevalence rates among the general population, research has clearly indicated a higher incidence among immigrant samples (Elizur & Perendik, 2003; Steinhausen et al., 2006; Toppelberg, Tabors, Coggins, Lum, & Burger, 2005). Notably, results from an Israeli study found the rate among immigrant children to be 2.2% (Elizur & Perendik, 2003). Toppleberg and colleagues (2005) explain that immigrant children with inhibited or shy natures, are susceptible to experiencing a high level of anxiety and self-consciousness in their new language, which can lead to avoidance of speech and selective mutism.

Age of Onset

The age of onset for this disorder is typically in early childhood, before the age of five (Black & Uhde, 1995). Although children generally display some symptoms of selective mutism before entering school from as young as age two, this disorder is commonly first identified during the school age years (Black & Uhde, 1995; Steinhausen & Juzi, 1996). At this time, symptoms tend to become obvious and detrimental, as pressure to speak increases and the child's social and academic functioning is impacted (Cohan et al., 2006). It has also been hypothesized that at this juncture, children with

speech or language difficulties, as well as propensities toward anxiety, first become aware of their speech differences relative to their peers and may become self-conscious and inhibited in their speech (Viana, Beidel, & Rabian, 2009).

Gender Differences

Most researchers agree that females have a higher prevalence rate of selective mutism than males, with a 1.0 to 1.6 male to female ratio (Dummit et al., 1997; Steinhausen et al., 2006). However, the study conducted by Bergman et al. (2002) reported an equal male to female ratio for students from kindergarten to second grade levels. Although no explanation has been offered by these authors, they surmise that selective mutism affects younger males and females at a similar rate, but affects more females in older grades.

Etiology

Early researchers have conceptualized selective mutism as a manifestation of unresolved psychodynamic conflict, a reaction to trauma (i.e., sexual abuse, early hospitalization, death of a close family member) or more distant/taciturn and overprotective/domineering personality traits in fathers and mothers, respectively. However, these explanations lack sufficient empirical validation (Dow et al., 1995). Notably, Cunningham, McHolm, and Boyle (2006) found no differences in parenting styles (i.e., permissive versus coercive) between the control and selective mutism groups. In fact, Yeganeh, Beidel and Turner (2006) suggest that children with selective mutism may be more likely to have accepting parents, especially when compared to children with social phobia, which may explain the increased severity of symptoms in the former diagnostic population. This is supported by previous research that demonstrates a

correlation between parents described as more accepting and children with behavior inhibition.

More recently, selective mutism is understood primarily through a multidimensional model, accounting for a combination of biological factors, temperament and anxiety (Dow et al., 1995; Steinhausen et al., 2006). As reflected in the research, children with selective mutim are often described as shy with a biologically determined sensitive temperament that can be observed in infancy (McInnes, Fung, Manassis, Fiksenbuam, & Rosemary, 2004). One study found that shyness was the most common character trait among those with selective mutism, present in about 85 out of 100 children, followed by anxiety, present in about 66.7% of the sample studied (Ford et al., 1998). In addition, family temperament, in regards to shyness and anxiety, is also positively correlated with children with selective mutism and may play a genetic and/or environmental role.

Classifications of Selective Mutism

Currently, there are no formal and distinct selective mutism classifications. Yet, several models have been suggested. Bergman and colleagues (2002) proposed classifications based on the duration of symptomatology. The *transient* form would include all cases of selective mutism resolved during the first year of school, while the *persistent* form would refer to long-term presence. Cunningham, McHolm, and Boyle (2006), utilizing the social phobia model, delineated selective mutism as falling in the *Specific* or *Generalized* categories, with individuals exhibiting higher levels of anxiety within the school setting, increased social deficits, and poorer adult outcomes for the latter distinction. Schwartz and Shipon-Blum (2005) view selective mutism severity as

falling on a continuum from *mild* and *moderate* to *moderately severe* and *severe*. Higher functioning children may speak single words and utter noises or sounds, accompanied by nonverbal interactions, but children with more severe profiles utilize less nonverbal communication and do not articulate sounds.

Is Selective Mutism a form of Anxiety Disorder?

Many current researchers believe that selective mutism is more appropriately conceptualized as a symptom or subtype of social phobia since most children with selective mutism also meet the criteria for social phobia (i.e., social avoidance, distress in social situations, fear of speaking to strangers) more than any other disorder (Bergman et al., 2002; Black & Uhde, 1992; Cohan et al., 2006; Dummit et al., 1996; Steinhausen et al., 2006). Both disorders share many similarities in etiology, male/female ratio and treatment, and the argument that selective mutism is a variant of social anxiety is a convincing one. Thus, a 1999 at an Anxiety Disorders Association of America conference sponsored by NIMH (National Institute of Mental Health) has even proposed the idea of reclassifying selective mutism as a subtype of social phobia in the new Diagnostic Statistical Manual (Bergman et al., 2002).

In the seminal study by Black and Uhde (1995), an astounding 97% of the participants with selective mutism also met the diagnostic criteria for social phobia. Symptoms generally associated with social phobia such as social avoidance, distress in social situations, and fear of speaking to strangers are typical in children with selective mutism. Furthermore, the pattern of severity of selective mutism symptoms among different situations mimics the pattern for adults with social phobia, which include increased comfort in small groups and among family and friends. Interventions,

especially pharmacological treatments are often effective for both selective mutism and social phobia (Black & Uhde, 1995).

In addition, the sex ratio, family history, and early and long-term behavioral presentations are remarkably parallel between social phobia and selective mutism. Higher rates are reported for girls for both disorders (Bergman et al., 2002). Seventy percent of parents of children with selective mutism had a personal history of social phobia or avoidant disorder (Black & Uhde, 1995) as well as a family background of depression and communication disorders. This may be a result of anxiety stemming from inherited communication and neurodevelopmental impairments or delays (Cohan et al., 2006).

Both populations exhibit similar early temperaments with behavior inhibition, difficulty with transitioning to new situations, or reluctance to speak (Bergman et al., 2002). Likewise, many of those who have recovered from selective mutism still have other anxiety symptoms as adults. In a long-term outcome study conducted by Steinhausen and colleagues (2006), the prevalence of residual phobic symptoms are equally high for those treated for selective mutism and those treated for social phobia, further supporting the idea that selective mutism is a variant of anxiety disorders.

A small number of differences do exist between selective mutism and social phobia. Besides the obvious inconsistency in talking behavior, the age of onset for selective mutism is generally younger, at five years of age, as opposed to age ten for social phobia (Bergman et al., 2002). Also, Yeganeh et al., (2006) discovered that children with selective mutism report lower levels of anxiety than do their peers with social phobia. This is inconsistent with teacher and parent ratings that indicate higher levels of anxiety in the former group. The authors conjecture that speech inhibition is

essentially an avoidant behavior, which likely attenuates some of the anxiety that those with selective mutism experience.

Differential Diagnosis

The diagnosis of selective mutism is not always obvious, as speech inhibition is commonly a symptom of pervasive developmental disorder (PDD), schizophrenia or severe mental retardation (McInnes et al., 2004). Until recently, the absence of a standardized evaluation tool to assess this specific disorder further complicated the diagnostic process (Schwartz & Shipon-Blum, 2005). Often, anxiety measures are utilized, which although useful, may fail to correctly identify selective mutism. Given the above limitations, many children receive inaccurate diagnoses, further delaying treatment (Schwartz & Shipon-Blum, 2005). Thus a comprehensive assessment that explores and compares speech and cognitive functioning in all settings should be completed (Dow et al., 1995). If speech is consistently absent in all settings and/or is attributed due to a cognitive or psychiatric impairment, selective mutism is generally ruled out (DSM-IV TR; American Psychiatric Association, 2000).

Higher rates of selective mutism are commonly present among bilingual immigrant children, thereby suggesting that second language development, or the stress related to this task, may play a role in the occurrence of selective mutism (Cohan et al., 2006). However to avoid over-diagnosis, practitioners must be mindful to allow recently immigrated children time for language acquisition. Since a silent period is typical for these youngsters, Toppelberg and colleagues (2005) advise that bilingual children, presenting with a selective mutism profile, should not be diagnosed until mutism is present for six months and is consistent in both languages.

Co-morbid Disorders

Children with selective mutism are more likely to suffer from internalizing disorders as compared to children in the general population (Cunningham, McHolm & Boyle, 2006). Some common psychiatric problems that may be co-morbid with selective mutism, include an increased occurrence of enuresis, encopresis, obsessive-compulsive traits, school phobia, depression, and developmental disorders or delays (Dow et al., 1995; Kristensen, 2000), as well as post traumatic stress disorders, separation anxiety (Schwartz & Shipon-Blum, 2005) and other phobias (Steinhausen et al., 2006). However, in contrast, children with selective mutism appear to have a lower prevalence of externalizing or behavioral disorders than the general population, which is consistent with research on social phobia (Cunningham, McHolm & Boyle, 2006).

Researchers disagree regarding the exact percentage of children with co-morbid speech and language delays. While some maintain that it is fairly rare (Schwartz, Shipon-Blum, 2005), McInnes and colleagues (2004) report that as many as 30-50% of children with selective mutism have co-occurring speech issues. Determining the extent and settings of the speech difficulties may be challenging to observe or to accurately assess from parent reports. A longitudinal study has linked early speech-language delays/disorders with the occurrence of social anxiety later in life (McInnes et al., 2004).

Most researchers do not believe that these children suffer from cognitive deficits (Cunningham, McHolm, Boyle, & Patel, 2004). However, the inability of these children to adequately demonstrate their full range of knowledge, and their lack of classroom participation, may impact their grades and teacher assumptions of their intelligence (McInnes et al., 2004). Their ability to learn and concentrate may also be significantly

impacted by the anxiety that typically accompanies selective mutism (Pionek-Stone, Kratochwill, Sladezcek, & Serlin, 2002). In addition, as rated by teachers and parents, these students present with social skill deficits, in regards to assertiveness, social responsibility and social cooperation, similar to those with social phobia. Yet, even with these weaknesses, children with selective mutism are likely to be accepted by peers and are not often targets of teasing or bullying. Parents also reported that the frequency of play and peer interactions outside of school did not differ for children in the target or control groups (Cunningham, McHolm, Boyle & Patel, 2004, 2006).

Assessment Process

As referenced in the literature, an estimated 40% of children with selective mutism are not properly diagnosed and/or referred for treatment (Cohan et al., 2006). Even when young children are referred**,** there is often a lapse of up to four years before treatment is initiated (Schwartz & Shipon-Blum, 2005). Thus, proper assessment is integral (Dow et al., 1995; Krysanski, 2003; Schwartz & Shipon-Blum, 2005).

Dow and colleagues (1995) recommend that mental health professionals first interview the child's parents to gather background information and glean a comprehensive list of symptoms. Inquiries should include developmental and medical histories, age of onset, degree of symptoms and socialization, as well as previous treatments and outcomes (Krysanski, 2003). It is important to ask about unusual symptoms that may indicate an inappropriate diagnosis of selective mutism and the possible presence of another psychiatric or neurological disorder. In addition, the child's temperament, degree and quality of interaction and communication both in verbal and nonverbal domains and abnormal speech issues, as well as academic abilities should be

explored through observation or indirect means. A traditional IQ test or interview may not be valuable for a child with limited verbal and nonverbal interaction. Family history of selective mutism, anxiety, extreme shyness and other psychiatric and medical disorders may shed light on the child's risk factors and thus may lead to a more accurate diagnosis. Psychiatric, neurological, developmental, clinical and speech-language evaluations should be completed (Dow et al., 1995; McInnes et al., 2004).

McInnes et al. (2004) and Dow et al. (1995) recommend that pragmatics, and phonological aspects of language be assessed in a speech and language evaluation by gathering information from the parents and through listening to a recording of the target child's speech. Assessing the child's narrative abilities can be helpful in discovering and addressing reading problems (McInnes et al., 2004). Likewise, auditory testing should be completed to rule out speech difficulties as a function of a hearing issue (Dow et al., 1995). However, Schwartz and Shipon-Blum (2005) maintain that only a small percentage of children with selective mutism, less than 25%, also have speech and language deficits. Thus, they advise against emphasizing speech issues or mandating speech therapy. Such actions, they rationalize, can exacerbate the already high levels of stress and anxiety these youngsters experience.

Dow et al. (1995) and Omdal and Galloway (2007) also recommend interviewing the child**.** An emphasis should be placed on the presented temperament, degree and quality of interaction and communication both in verbal and nonverbal domains. Omdal and Galloway (2007) suggest that projective tools such as the Raven's Controlled Projection for Children (RCPC) may be useful in gathering information and treating the child with selective mutism. This instrument, does not require talking, but rather asks the

youngster to write a story about a child that is guided by questions the evaluator asks throughout the administration. Inquiries probe the character's likes and dislikes, friendships, fears and other personal feelings and traits. In this way the silent child, whose opinions and needs are often not included in the research, can communicate inner feelings and struggles in a non-threatening and nonverbal manner. In their small study, some important themes specific to each child were uncovered (e.g., school refusal, family issues, social difficulties). The authors hypothesized that addressing these feelings can help the child to respond to treatment.

Until very recently, no statistically sound screening measures were available to assess the severity of speech inhibition across different settings in selectively mute children (Letamendi et al., 2008). Rather anxiety measures and behavior rating scales have been used in conjunction with the Diagnostic and Statistical Manual criteria to explore the child's talking behaviors. However, the Selective Mutism Questionnaire (SMQ) created by Bergman (2008), as demonstrated in preliminary studies is the first reliable and valid measure for assessing the severity of mute behaviors across different settings (Letamendi et al., 2008). This measure is a 17-item parent rating scale that includes questions such as *my child speaks in groups or in front of the class; my child speaks to most peers at school;* and *my child talks to family members when in unfamiliar places.* However this scale is limited in its use, as it has only been empirically studied for its ability to assess symptom severity in children already identified with this disorder; no data is yet available regarding the SMQ's validity or reliability as a diagnostic tool for selective mutism.

Interventions for Selective Mutism

Goals of selective mutism interventions. Currently, the maintenance of selective mutism symptomatology is most often perceived in accordance with the behavioral tradition, in which environmental responses sustain the non-talking behaviors. To counteract these reinforcing mechanisms, most researchers agree that the primary goals in working with a child with selective mutism are to decrease anxiety and remove the negative reinforcement of mute behaviors (Elizalde-Utnick, 2007; Krysanski, 2003). Instead, behavior interventions that include a hierarchical process which include expectations for the child to communicate first nonverbally and ultimately verbally are recommended (Dow et al., 1995).

Specific selective mutism interventions .Treatments for selective mutism have evolved in parallel to the understanding of the etiology of the disorder. Previously, psychodynamic and family therapies were the treatments of choice. Respectively, they focused on resolving intrapsychic conflict through play therapy and understanding and eliminating the function that the child's selective mutism serves within the family. Due to their lengthiness, limited empirical support, lack of generalizablity and unknown long-term success (Anstendig, 1998; Dow et al., 1995), these interventions have been substituted by cognitive-behavioral therapies (CBT). However, the family is still an important component for collaboration and involvement in CBT interventions (Dow et al., 1995).

In their synthesis of the selective mutism treatment literature, Pionek-Stone and colleagues (2002) found: (a) any treatment is better than no treatment; (b) behavioral interventions are better than other treatments, and (c) the results of two behavioral

intervention models did not significantly differ from one another. Although much intervention research has been completed, we still do not know of one intervention that is consistently successful in treating this complicated and persistent disorder (Krysanski, 2003; Sanetti & Luiselli, 2009; Schwartz & Shipon-Blum, 2005). Rather, a multi-method behavioral approach individualized to the particular client is the recommended best practice (Krysanski, 2003).

Anxiety reduction interventions, including behavioral, cognitive-behavioral and pharmacotherapy approaches, are currently the preferred treatments, as they are evidenced based and empirically supported. In a comprehensive meta-analysis of selective mutism treatment, Cohan, Chavira, and Stein (2006) state that CBT approaches, which include anxiety management approaches and parent psychoeducation, have successfully demonstrated a reduction in anxiety and selective mutism severity in different settings, especially for older children

Behavioral and cognitive behavioral interventions utilize reinforcement, shaping, stimulus fading, desensitization, social skills training, modeling and response initiation techniques (Cohan et al., 2006; Dow et al., 1995; Krysanski, 2003; Schwartz & Shipon-Blum, 2005). In the 1960's Reed was the first to conceptualize selective mutism as a learned behavior, which functions as a way to either gain attention or escape from anxiety, maintaining this behavior (Cohan et al., 2006; Dow et al., 1995). Thus, treatment with this approach is aimed at removing the stimulus which increases attention and mitigates the anxiety (Dow et al., 1995). For mute behavior, some studies eliminated the reinforcement, while others used punitive measures. However, use of punishments may be counterproductive as they tend to increase anxiety (Cohan et al., 2006).

Stimulus fading, which gradually increases the difficulty of the task working up to normal speech with a larger audience, is used with children with social phobia.. The therapist may also use modeling and social skills training to demonstrate how to cope with anxiety driven situations (Schwartz & Shipon-Blum, 2005). *Self-modeling*, through the use of edited videos portraying the child speaking in targeted environments, i.e., classroom, have been significantly effective, as the child grows accustomed to and becomes less anxious about speaking in other environments (Dow et al., 1995). A similar method of editing audio tapes was employed by Blum and colleagues, and was met with varied success since some children refused to participate (Blum et al., 1998).

Systematic desensitization, a technique promising results, involves the combined use of relaxation skills and gradual exposure from the least to most anxiety provoking situations. Other interventions, such as *exposure*, are similar to the above, but slowly increase the number of people and situations in which the child talks (Cohan et al., 2006). With *shaping*, reinforcement is provided for increasingly more communication, which may begin with pointing, mouthing and then progress to whispering to brief responses to full communication. *Response initiation* (Krysanski, 2003), another behavioral intervention that can last several hours during the initial session, requires that the child verbalize one word to the therapist before leaving; most children talk within one to two hours. Subsequent sessions work on more challenging goals.

Phenelzine and fluoxetine, medications that have been effective in treating social phobia, are also successful in relieving the severity of selective mutism symptoms in children with a co-morbid anxiety disorder (Dow et al., 1995; Dummit et al., 1996). When administered, they are generally not used in isolation, but rather in conjunction

with behavioral interventions (Cohan et al., 2006). Carlson, Mitchell and Segool (2008) in their comprehensive overview exploring pharmacological treatments state that few physicians actually prescribe medications due to the limited number of, albeit seemingly robust, studies. It is still unclear if medication is useful for the entire selective mutism population or only those with a coexisting anxiety disorder (Krysanski, 2003).

In a treatment comparison study, Manassis and Tannock (2008) found that children treated with selective serotonin reuptake inhibitors (SSRI) evidenced more improvements when compared to their non-medicated peers with selective mutism. However, it is important to note that this study included a non-randomized small sample and did not explore the effectiveness of SSRI's in isolation of other interventions. To date, SSRI's appear to be the most promising for children with chronic selective mutism that is not responsive to other treatment modalities (Carlson et al., 2008), as well as older children (Schwartz & Shipon-Blum, 2005).

Response to intervention. Selective mutism is especially resistant to intervention, making it a very difficult disorder to treat (Kyrsanski, 2003; Sanetti & Luiselli, 2009; Schwartz & Shipon Blum, 2005). Escape from anxiety, in the form of mutism, is a powerful, albeit non-adaptive, coping mechanism that children do not readily abandon (Cohan et al., 2006; Dow et al., 1995). Negative reinforcement for mute behaviors (e.g., a teacher withdraws his/her expectation for a student to speak when no response is forthcoming), as well as reinforcement given by others for nonverbal communication also serve to strengthen the mutism (Krysanski, 2003). In addition, as some individuals who recovered from this disorder attest, he or she feels bound by the social role of the "quiet one," unwittingly assigned by peers (Omdal, 20007).

Thus, as with anxiety, early intervention and referral are crucial (Auster, Feeney-Kettler, & Kratochwill, 2006; Cohan et al., 2006; Schwartz, & Shipon-Blum, 2005). The longer a child is mute, the more the behaviors and mechanisms become crystallized, thus decreasing the efficacy of interventions (Krysanski, 2003). Pediatric literature, stating that symptoms usually resolve after a few months, is misguided; unfortunately, this erroneous information results in many late referrals and missed opportunities for treatment (Schwartz & Shipon-Blum, 2005).

Selective Mutism in the Educational Setting

Selective mutism in the classroom. The school setting is the primary context for the initial manifestation of selective mutism. Some common behaviors exhibited by this population include: standing or sitting motionless when anxious, not responding when asked a question, heightened sensitivity to sensory input or crowds, as well as difficulty with social routines where speech is involved (Elizalde-Utnick, 2008).

Most often, the inability to speak interferes with the student's ability to function socially and academically in the classroom, with both peers and teachers. Socially, these children can be infantilized by peers, ignored (Elizalde-Utnick, 2008) or, although uncommon, also bullied (Schwartz & Shipon-Blum, 2005).

In addition, as discussed previously, selective mutism may be maintained unwittingly by teachers or classmates who do not want to pressure the student to talk or who answer for the student. It is thus logical that the school is an ideal environment for treatment generalization, rather than a clinic setting alone (Bergman et al., 2002; Sanetti & Luiselli, 2009; Schwartz & Shipon-Blume, 2005; Stone, Kratochwill, Sladezcek, & Serlin, 2002). Previous studies have found that only 60% of children with this disorder

receive treatment (Black & Uhde, 1995; Dummit et al., 1997) and without treatment most remain impaired (Bergman et al., 2002). Therefore, it is essential that school personnel acquire knowledge and skills to develop intervention plans for students with selective mutism (Sanetti & Luiselli, 2009).

Role of teachers. Teachers often have the greatest responsibility in trying to decrease fearfulness and to encourage interaction in an anxiety provoking setting. Parents and clinicians expect educators to demonstrate the right balance of refraining from forcing the child to talk, while at the same time encouraging communication, without overemphasizing verbal performance (Elizalde-Utnick, 2007; Schwartz & Shipon-Blum, 2005). Recovered individuals, as well, often view teachers as very influential determinants in their maintenance or recovery of selective mutism (Ford et al., 1998; Omdal, 2007).

Ford and colleagues (1998) interviewed individuals who suffered from selective mutism as children. Subjects were asked to identify what they believed helped them recover. The first ranked response was interventions using gradual steps or fading, followed equally by teacher/school support and parent-school collaboration. These responses highlight the importance of the teacher's role.

Unfortunately, the reverse is also true. In Omdal's (2007) study of a similar nature, one woman reported that her teachers were not understanding of her disorder and did not encourage her to socialize with others or express herself. Two other study participants shared that their teacher did not intervene when others bullied her. It can be hypothesized that the absence of teacher involvement or empathy was likely due to lack of knowledge or exposure to the disorder. This can then contribute to missed referrals,

delayed treatments, false assumptions that symptoms will remit on their own, or beliefs that the student is intentionally and defiantly not speaking.

In Watson and Kramer's study (as cited in Anstendig, 1998), utilizing a multimethod behavior approach in different settings, talking behavior increased; however, it was not maintained within the school environment. The researchers attributed the limited success to several factors that include: shortage of time for teachers to implement the intervention, insufficient teaching training, and lack of teacher support during this process. In another study, teachers reportedly did not fully implement all aspects of the target intervention, possibly affecting treatment consistency and outcomes (Fisak, Oliveros, & Ehrenreich, 2006). Although the reasons for lack of teacher follow-through were not discussed in the study, the above factors were hypothesized to play a role. Auster and colleagues (2006) acknowledge the need for anxiety reducing interventions to include a consultation piece that educates parents and teacher in identifying symptoms, initiating the referral process and learning intervention strategies.

Thus, it is evident that teacher knowledge, attitude, and resources (e.g., time to implement interventions) are essential factors contributing to a student's comfort level and remediation. As experienced first-hand by subjects, misguided thinking by a teacher can be very damaging. Not only is the mute behavior more likely to persist, as a result, but the student's confidence and overall school experience can be negatively affected. In addition, lack of treatment integrity or success in the school setting, possibly stemming from the teacher's lack of time or understanding, can inadvertently mitigate treatment results. Thus, it is quite surprising that, although a great deal of current research posits that teachers play a vital and unique role in the assessment and intervention processes

(Anstendig, 1998; Auster et al., 2006; Bergman et al., 2002; Cohan et al., 2006; Dow et al., 1995; Elizalde-Utnick, 2007; Fisak et al., 2006; Ford et al., 1998; Krysanski, 2003; Omdal, 2007; Sanetti & Luiselli, 2009; Schwartz & Shipon Blum, 2005), no research has yet explored teachers' knowledge and needs in supporting children with selective mutism.

Lack of research regarding school interventions for selective mutism. There is a lack of evidenced-based research studies focused on school-based treatment for this disorder (Auster et al., 2006; Cohan et al., 2006). Thus, school approaches are often derived from anxiety research; anxiety is the most common DSM diagnosis among children and adolescents, reportedly affecting about 6-18% of children ages 6 to 17. Although selective mutism, like anxiety, tends to worsen over time and early intervention is crucial for both (Auster et al., 2006), there are still distinctions, namely in talking behaviors, that may not be addressed by the research on anxiety (Letamendi et al., 2008).

Researched-based school interventions. Research recommends that teachers and other school staff employ cognitive-behavioral interventions (Krysanski, 2003). This includes, shaping or creating a hierarchy with small benchmark goals (e.g., to gradually increase the volume, number of verbalizations, as well as the group size) that are reinforced when met. The teacher should collaborate with the student regarding preferred rewards and when they will be given. Rewards should be faded as the student progresses (Krysanzki, 2003, Sanetti & Luiselli, 2009). However, it important to keep in mind that research demonstrates that positive reinforcement, whether provided by teachers or peers, is only effective in the short-term (Krysanski, 2003). Perhaps, this is due to decreased or inconsistent expectations for talking behaviors from subsequent teachers.

There is some disagreement in the literature on how to respond to nonverbal communication. Some advise against reinforcing gestures or other nonverbal means of communication (Krysanski, 2003), while others strongly feel that any attempt to communicate such as using facial expressions, mouthing, and speaking through an intermediary, should be recognized and rewarded (Schwartz & Shipon-Blum, 2005). However, all agree that once a child has graduated to a more verbal form of communication (i.e., whispering), nonverbal means should be faded.

To generalize speech to other individuals in school, Sanetti and Luiselli (2009) advise that the teacher or other school personnel should assist the student in creating and rating a list of individuals to whom he or she would like to speak. The first goal would be to talk to the parent in a new environment (i.e., school) via a relaxed activity of the student's choosing which only requires predictable speech (e.g., playing a game with a verbal component or answering simple questions). Then the teacher, or other individual to whom the child does not talk, gradually approaches the talking situation and finally engages in the game or activity. Slowly the parent is faded out of the room in reverse fashion. Other individuals can now be added to join the teacher and child's activity (Sanetti & Luiselli, 2009).

Classroom modifications and strategies. Children with selective mutism may have difficulty receiving emotional support in school. Thus, visiting a child at home may provide essential information for the teacher regarding the child's interactions and experiences in the home environment, as well as his/her need for support. Having the child draw or write is another strategy for understanding the needs of the selectively mute student (Omdal, 2003). It may be beneficial to request a home video from the parents so

the teacher can witness talking behaviors and abilities present in the home environment (Schwartz & Shipon-Blum, 2005)

Schwartz and Shipon-Blum (2005) offer strategies for helping children with selective mutism manage at school. Encouraging students with this disorder to work in small groups, as well as pairing them with children that can serve as good social models, can help mitigate anxiety and increase communication and social skills. Also to prevent bullying, it is beneficial for the teacher to educate the class about the disorder and explain the effects of teasing or bullying.

In terms of academic modifications, Schwartz and Shipon-Blum (2005) recommend that an IEP, with the classification of Other Health Impairment or a 504 plan be written, and executed, accordingly. Testing modifications such as extended time limits and separate testing location should be implemented to reduce the likelihood of test anxiety. They also suggest that direct parent involvement in the classroom be allowed initially and then reduced and possibly replaced with a cell phone. To increase nonverbal communication, flashcards or a pocket flashlight can be utilized by the child to indicate "yes" or "no" to questions, as well as a finger puppet to act as a communication surrogate.

Elizalde-Utnick (2007) suggests that modifications be made in the classroom initially to help the child feel secure, then to gradually introduce increasingly anxiety inducing situations (e.g., larger group setting) in which the child is helped to adjust and overcome. School-based counseling is also recommended, which can also serve to help the child express his or her feelings and to feel more confident, as well as utilizing small settings to initiate the interventions. Children are often afraid of the reaction of others to

their first spoken word and are thus inhibited by the "start barrier." It is interesting that female therapists have been found to be more effective and have a greater calming effect with female children with selective mutism (Elizalde-Utnick, 2007).

Education and collaboration: Necessary components for successful school interventions. Given the confusion surrounding this disorder, all members of the treatment team, including parents, teachers, physicians and relatives should be educated on symptoms and interventions strategies and/or referred to informative websites (Schwartz & Shipon-Blume, 2005). Collaborating on setting treatment goals and implementing interventions between all involved members, are essential for treatment success (Auster et al., 2006; Dow et al., 1995; Elizalde-Utnick, 2007; Krysanski, 2003; Schwartz & Shipon-Blum, 2005). It is especially important that parents are involved in the school's response, as parents play a role in reducing their children's symptomatology. In fact, research has demonstrated that children fared better, at six months to a year following treatment, when CBT and family consultation were jointly applied, as opposed to CBT implemented in isolation (Auster et al., 2006).

The Surgeon General's report in 1999 indicated that schools and other settings servicing children do not implement sufficient evidenced-based programs, partly due to lack of available consultation, a necessary prerequisite for appropriate application of programs. Conjoint Behavioral Consultation, as described by Auster and colleagues (2006), is a collaborative and indirect service delivery model in which consultees are guided on implementing the intervention appropriately and with better outcomes. For instance, for anxiety, this approach allows the consultee to learn and recognize the

symptoms of anxiety, learn referral procedures, and develop intervention strategies to help the child and other future children with anxiety-related symptoms.

Long-Term Effects of Selective Mutism

As previously mentioned, due to the lack of research, as well as the multidimensional aspects of this disorder, little is known about the course. It appears that selective mutism is a chronic disorder that leaves residual effects such as anxiety in social situations even after remission (Cohan et al., 2006). As pediatricians Schwartz and Shipon-Blum (2005) have pointed out, pediatric medical manuals offer only limited and often inaccurate information, such as advising doctors that symptoms are likely to naturally remit. Although, non-referred children with selective mutism may experience some spontaneous recovery or improvement, without formal treatment they will most likely remain symptomatic (Bergman et al., 2002; Schwartz & Shipon-Blum, 2005).

Notably, in a longitudinal study completed by Remschmidt and colleagues (2001), 60% of individuals who had selective mutism as children reported that they suffered from problems with self-confidence, independence, achievement, and social-communication skills. Similarly, Steinhausen et al. (2006) found that even those who overcame the fundamental selective mutism symptoms are likely to have residual issues in the social and communication domains, as well as a higher rate of unemployment. They postulate that lower intelligence of the individual and mute behavior within other members of the family environment may influence a more negative outcome.

In their nation-wide study, the first of its kind for selective mutism, Ford and colleagues (1998) surveyed a relatively large sample of 153 parents of children with selective mutism or adults with selective mutism. When interviewing those that have

recovered, they sought to understand the mechanisms or interventions the adults felt aided in the process. The most frequently stated attributions for recovery included: gradual steps/fading, teacher/school support, parent school collaboration, family support, psychologist involvement, and use of a reward system.

Missing Elements in Current Research

Empirical literature base remains limited for selective mutism, especially in regards to prevalence, referral/treatment rate and evidenced-based interventions. Although numerous interventions are described in the literature, research does not include which treatment is typically given to children with selective mutism, the ratio of those with this disorder that are treated or unsuccessful treatments that were attempted (Cohan et al., 2006). In addition, the lack of sufficient program and intervention descriptions render reported interventions almost impossible to replicate (Dow et al., 1995; Cohan et al., 2006). Notably, most studies of selective mutism interventions include a small sample size with no control group, as well as the lack of standardized diagnostic tools or outcome measures. Longitudinal designs are generally absent so long-term outcomes are difficult to predict and the effect of other extraneous variables are often not considered (Dow et al., 1995).

Given that school is the primary setting for the initial and continued manifestation of selective mutism symptoms, it is surprising that there is a dearth of evidenced based research studies focused on interventions that teachers and school staff are utilizing (Auster et al., 2006). This deficiency, as well as a lack of screening tools designed for teachers, likely contributes to the lack of a proper referral and treatment procedures in the schools. Thus, research is needed to understand students' presentation of selective

mutism, as well as the needs of teachers, including their knowledge of selective mutism and choice of interventions. The current study attempts to fill in this gap in literature, by exploring teacher knowledge and needs regarding selective mutism to understand what is needed to better support both teachers and students in the school environment.

Chapter 3

Research Methodology

Participants

Teachers. Participants in this study included six teachers from four Manhattan area public elementary and junior high schools, who recently taught a child with selective mutism (83.3% during the 2009-10 school year, 16.7% during the 2007-2008 school year). Students were diagnosed with selective mutism by an outside professional or suspected to have selective mutism by school staff, due to lack of speech in the classroom, while presenting with normal speech at home. Schools with students with selective mutism were identified at a Manhattan-wide meeting for social workers and psychologists in the New York City Department of Education in November 2010. Specifically, this was done on a voluntary basis as an appeal at the end of the meeting; an announcement was made for "those working in schools that have children who appear to present with selective mutism or speak minimally within the school setting" to add their name, the school's name and phone number on a sign-up sheet created by this researcher. Sixteen schools listed on the sheet were then contacted by this researcher, by phone and mail, to obtain consent from both principals and teachers before conducting interviews. Subsequently, four schools were found to no longer qualify, as the students did not currently attend the schools or the students were no longer considered to have selective mutism by the teachers or principals. Of the remaining twelve qualifying schools, one principal denied consent and another principal could not contact the teacher; the rest of the schools did not reply to mailings or phone calls. Only four principals responded that they were willing to participate (response rate 27%). With one or more teacher

participating from each of these four schools, a total of six teacher participants were obtained.

Teachers were given identification numbers ranging from1- 6. All teachers included in this study were female and held a Master's degree in education, with 66.7% in special education and 33.3% in regular education. Teacher B also earned a Master's degree in a mental health field and this teacher, as well as teacher 5 had previously worked with children diagnosed with psychiatric disorders. At the time of this study, two-thirds (66.7%) of the participants were teaching in a collaborative team teaching classroom, while Teacher 5 taught a small special education class and Teacher 2 taught an honor's class. Eighty-three percent of the sample was an elementary teacher and only Teacher 2 taught at the middle school level. The average number of years of teaching was 4.8 years (SD = 2.1).

No teacher had prior experience teaching a student with selective mutism. However, Teachers 3 and 4 taught Student C in two different grades and Teacher 5 taught student D for two consecutive years. Refer to Table 1 for a summary of teacher demographics.

Table 1

Teacher Demographics

Teacher ID #	Years of Teaching	Highest Degree	Grades Taught	Type of Class/Subjects Taught	Student ID
1	3	Master's in general education	Kindergarten	Collaborative Team Teaching	A
2	4	Master's in general education	Junior High School and High School	Science – Honors class	B
3	4	Master's in both mental health and special education	4th and 5th grades	Collaborative Team Teaching	C
4	7	Master's in special education	2nd grade	Collaborative team Teaching	C (same student as above in a previous grade)
5	4	Master's in general and special education	3rd and 4th grade bridge class	Self contained special education class with 12:1:1 ratio	D (second year teaching this student)
6	7	Master's in Literacy Licensed in both general and special education	4th grade	Collaborative Team Teaching	E

Students. The information of five students was collected through teacher interviews. Students were not contacted directly or identified by name at any time during this study. All students targeted in this study were female and were in elementary grades, except for one in junior high school. Excluding this one teen student (Student B), whose time of referral is unknown, the students have been identified with selective mutism at the Kindergarten level. Mean duration since diagnosis was four years. The mean current age of students in the sample was 11.8 years (SD = 3.05) and mode grade of 4^{th}. Four students (80%) were Caucasian and one (20%) was Hispanic. Although all students reportedly were dominant in English, 60% understood or spoke another language, i.e., Portuguese, Spanish and an unknown European language. At the time of the study, 40% of the student sample was taking prescription anti-anxiety medications. In addition, other medical issues were identified such as asthma and possible malnourishment for Student A and Student D's mother had a history of mental illness, which resulted in a tragic death about a year ago. Refer to Table 2 for a summary of general student demographics.

Regarding special education services, all students (80%), excluding Student B, were classified, had an individual education plan (IEP) and received special education services, determined by the school-based support or IEP teams based on academic delays. Delays limited to reading and writing (40%) accounted for half of these students; the other half demonstrated delays in all academic areas (40%). Educational classifications on the IEP's included the following: Learning Disability (40%), Emotional Disturbance (20%) and Speech or Language Impairment (20%). The remaining student, Student B, was in an honors program in middle school. Sixty percent of classified students received instruction in collaborative team teaching classrooms, which are integrated settings

consisting of classified and non-classified students and are taught by two teachers (one general education and one special education teacher). Student E was in a small special education classroom with a 12:1 student teacher ratio. Regarding other educational services, 80% of students received one or more of the following: counseling (80%), speech therapy (40%) and occupational therapy (20%). Two students (40%) presented with speech issues; notably, Student C spoke with a slight lisp and Student D presented with articulation and receptive delays. Refer to Table 3 for a summary of student demographics as relating to academics.

Table 2

Student Demographics

Student ID	Gender	Age	Grade	Ethnicity	Years with identified SM	Medical Status	Dominant Language(s)
A	Female	6	Second year of Kindergarten	South American/ Caucasian	2	Bad Asthma Looks malnourished to teacher	English but understands Portuguese
B	Female	13	8th grade	Caucasian-European Immigrant	Unknown – mom reports symptoms since immigrating to the US – teacher is unaware of year	Taking Anxiety Medication for ½ year	English and Unknown European Language
C	Female	10	4th grade	Caucasian	5	Taking Anxiety Medication	English
C	Female	8	2nd grade	Caucasian	3	Unsure if took medication at time	English
D	Female	10	4th grade	Hispanic	5	Father opposed to medication History of psychiatric illness in family	English and Spanish
E	Female	10	4th grade	Caucasian	4-5	No health Issues or medication	English

Table 3

Student Demographics II (academics)

Student	Educational Classification	Educational Services	Speech or Language Issues	Academic Skill Levels
A	Learning Disability (LD)	Collaborative Team Teaching (CTT) Speech was terminated, as student did not present with a comprehension or speech production issue	None reported	Reading skills & writing below grade level Grade level math skills
B	None	No IEP- but does receive school counseling	None reported Teacher is unsure if student speaks with an accent	Above grade level – in Honors classes
C	Emotional Disturbance (ED)	CTT with Occupational Therapy (OT) and counseling	None reported	Almost on grade level for most skills, except weak writing Disorganized
C	Emotional Disturbance (ED)	CTT with OT and counseling	Slight lisp	Reading and writing below grade level Disorganized
D	Speech Language Impairment (SI)	Self contained class with Speech, counseling ESL services terminated due to student's discomfort in attending	Weak receptive language and poor articulation ELL (English Language Learner)	1 ½ years below grade level

Table 3 – continued

E	Learning Disability (LD)	CTT English Counseling and speech	None reported	All skills below grade level Low motivation and often did not complete homework

Measures

Because the schools involved were geographically far from each other and due to the low feasibility of conducting face-to-face interviews, phone interviews were conducted with the six participants, using the *Semi-Structured Interview for Teachers of Students with Selective Mutism* (see Appendix A). This interview form consists of both open- and closed-ended questions and was created for this study, based on results from the focus group conducted earlier, to gain an understanding of the teachers' knowledge and experience in teaching a child with selective mutism. The interview sought to explore the following domains: (a) demographics of teachers and students, 18 items; (b) teachers' knowledge of selective mutism, 6 items; (c) the typical referral process for these children, 7 items; (d) interventions that were most commonly employed in the classroom, 12 items; (e) behavioral, academic and social presentation of the student in school and home, 10 items; and (f) the needs of teacher in terms of additional support or professional development, 7 items. The interview was conducted individually with each teacher for approximately an hour to discuss all interview questions. Participant responses were recorded in written form by the researcher during the phone interview. Although behaviors and concerns relating to specific children were discussed, the identities of students were not divulged in order to maintain confidentiality.

Procedures

Once both principals and teachers provided written consent for participation in the study, teachers were contacted via phone and/or email to schedule a time for the phone interview. Teachers were then called by the researcher at scheduled times. The researcher used an interview form detailing teacher ID#, when interviewing each participant, so the interviewer could properly organize, record and summarize teacher responses; teachers did not have access to interview forms. For the most part, questions were taken from the interview forms, although some of the questions may have been reworded. However, at times, when additional clarification was needed or the teacher presented a new idea, follow-up questions that were not included on the form were asked (e.g., When did the child come to this school? Where did the child move from?). In addition, the sequence of interview questions differed during each interview, as often the teacher's responses of previous questions provided a natural segue into another topic that was to be queried. Also, to limit redundancy and keep within the hour time frame, questions were omitted when answers were provided in a discussion for other items. At the close of the interview, once all domains were discussed and recorded in written form by the researcher, the participant was thanked for her time and was asked whether she would agree to a follow-up interview, if necessary. All participants agreed, but none were contacted again.

Data Analysis Plan

In order to organize and analyze the survey data, the researcher created a outline that divided the collected information into the following domains: (a) teacher demographics, (b) student demographics, (c) referral history and outcomes, (d) teacher

knowledge, (e) outside services/consultation with others, (f) use and success of interventions, (g) method of learning assessments, (h) behavior, affect, and learning of student, (i) odd behaviors or talents, (j) social skills, interaction with peers, self-help, and (k) behavior at home. Under each identified domain, the related responses for each participant were labeled by ID # and summarized in sequence. Responses between teachers were analyzed for differences and similarities in each assessed area. Responses were then tallied and frequencies and percentages were calculated and reported (e.g., similar type interventions or talking behaviors of students).

Chapter 4

Results

Interview responses were analyzed using descriptive statistics, frequencies and percentages. In addition, responses were analyzed qualitatively to gain an understanding of teacher's knowledge, needs, and attitudes in identifying, referring, and teaching children with selective mutism. Below, each research question is stated and analyzed.

Research Questions

1) What do teachers know about selective mutism in terms of symptomatology and etiology?

Teachers were asked several questions to probe for their knowledge of the symptoms and underlying cause(s) of selective mutism, as well as knowledge of possible differential diagnoses. All teachers listed non-talking behaviors in certain situations as a symptom of selective mutism. In terms of identifying the underlying issue, although all participants mentioned that anxiety or nervousness may be present in these children, only 50% (three teachers) clearly identified anxiety as the main cause of this disorder. The remaining three teachers attributed poor social skills, trauma and lack of confidence/shyness. Teacher 5, specifically, felt that Student D developed fears as a result of the trauma she experienced (e.g., loss of her mother following a mental illness), which may have had a role in her lack of talking behaviors. All of the participants stated that their initial goal was to make the student feel comfortable in the setting, by not highlighting issues or pressuring the student to speak.

When asked to identify other possible reasons for a lack of speech, teachers listed a variety of factors such as: shyness (50%), control (17%), fear (17%), insecurity (17%), need to feel in control of emotions (8%), perfectionism (8%),or being teased by others (8%). None of the participants were able to provide the differential diagnoses as stated in the DSM-IV that include the presence of another spoken language or other disability such as MR or autism. Yet, 50% touched upon learning or speech issues as possible alternative explanations for lack of speech; specifically, they explained that a child may not talk in the classroom if he or she is confused, lacks vocabulary, lacks comprehension or has expressive language difficulties.

2) What do teachers in this sample report in regards to their students' (with selective mutism) presentation in the classroom (i.e., social, talking and academic behaviors) and at home, as per children's parents?

The following behaviors were reported for 80% of the target students (but not necessarily the same students): high level of compliance in the classroom; greater comfort around peers as compared to adults (e.g., more likely to interact via nonverbal means or whisper when in the presence of other students); and a high degree of stubbornness or oppositional behavior at home when interacting with their parents. Sixty percent of the students presented with little or flat affect; likewise 60% did not express their needs even in a nonverbal manner and would wait for the teacher or peer to notice. Forty percent of the students presented with the following: high intelligence, as reported by teachers; poor eye contact; high level of nervousness (i.e., profuse sweating, 20%; blushing when asked a question, 20%); perfectionistic qualities when completing school work (e.g., over erasing; becoming agitated when incorrect); gross motor issues (i.e.,

floppy body, 20%; slow labored movements, 20%); standoffish or exclusive with certain peers (e.g., only was agreeable to work or socialize with certain peers to the exclusion of others); poor motivation or effort during academic tasks; demonstration of a clear talent (i.e., music, 20%; art, 20%) and frequent lateness to school due to tantrums or arguments with parents at home.

The following unique behaviors were reported for individual students in the sample: refusal to eat in a group, but would turn towards the wall when eating (Student A); experienced toileting accidents in the beginning of the school year (student A); very organized and diligent (Student B); passive control issues (i.e., Student C would passively refuse to stop reading or completing other enjoyed activities when instructed and would seem as if she "was trying to catch an adult not following through"); highly aware of environment (Student C described by teacher like a "deer in headlights"); very disorganized (Student C); poor fine motor skills (Student C); strange phobias of costumes and noises that easily induced crying (Student D); excessive talking to peers only even during lessons, which required some teacher discipline (Student E) .

Talking behaviors for students are discussed below. All students began the year without talking. However, sixty percent of the student sample would respond nonverbally (e.g., nod, point or mouth responses) to questions posed by teachers. The remaining two students (Student A and D) presented as highly withdrawn and fairly nonresponsive (even nonverbally) at the start of the school year. As the year progressed, interaction and talking behaviors increased for 100% of the students, albeit to different extents.

Student A was reported by peers to talk to them a couple of times. Student B spontaneously emailed a request to her and also verbally responded when a male student

asked for her phone number. Student C began responding in a near audible tone of voice with pauses prior to speaking, which was accompanied by an increase in assertive and stubborn behaviors. Students D and E began whispering to teachers and Student E spoke comfortably with a select group of students. It is interesting to note that Student C, began both school years (2nd and 4th grades) with her respective teachers not talking. Yet she did demonstrate progress during both years, with greater progress in fourth grade. Notably in fourth grade, instead of just whispering, she spoke in a near audible tone, although with some remaining nervousness and atypicalities (i.e., long pauses, need for encouragement, spoke to only select peers).

All of the elementary students (80% of the total sample) were accepted and well regarded, and sometimes coddled (i.e., guided or protected, perceived as a younger child) by their peers, yet were often labeled by their classmates as children "who do not talk." Student B, the only student in middle school, was generally accepted by her peers, who voluntarily tried to assist her when necessary. However, at times, especially during group projects, her classmates would become frustrated with her lack of verbal participation and, as a result, a team member once requested to be transferred to another group.

3) **What is the referral process for this sample? For example, who refers these students and to whom are these children referred? What is the average time span from the identification of a problem to a diagnosis of selective mutism?**

Given the fact that all students targeted in this study were previously identified with selective mutism, detailed referral information was unavailable to the participants or researcher. Yet, participants reported that for 80% of the children, symptoms were first observed in Kindergarten or at the beginning of formalized school. Teacher 2, a middle

school teacher, did not know what grade selective mutism was first manifested for student B; she was told by the mother that it began when the student immigrated to the U.S. So far, the duration of selective mutism symptoms for these students ranged from 2 to at least 5 years. Full remission of symptoms has not been reported for any student.

4) Once children are identified, what strategies do teachers use, if any? How do they measure or know that these strategies are working? Where or from whom do teachers learn these strategies (e.g., School Psychologists, Web)?

During interviewing, this question was queried in an open-ended manner where participants were asked to share the modifications or interventions they implemented to help the student with selective mutism. This question was related in this manner deliberately in order to attempt to gain as much information as possible, rather than limiting responses to those provided on a checklist. However, it is possible that teachers may have omitted some interventions they employed, due to not considering them as such and thus, are not reflected in the data below.

Findings indicate that 100% of teachers utilized one or more classroom modification that they had developed on their own or through consultation with other school staff (i.e., previous teachers -50%, speech therapist-16.7%). Consistent with recommendations suggested by researchers, all teachers employed prompting, encouragement and individual attention (e.g., positive reinforcement, frequent check-ups to see if assistance was needed) to support the student and likewise, all teachers actively refrained from pressuring the student to talk (e.g., not coercing, punishing or providing extensive praise for talking). Although all teachers accepted and responded to nonverbal responses from their student with selective mutism, 50% of the sample incorporated

formal use of nonverbal means such as: sign language for bathroom or other needs, picture cards, and use of a white board. Similarly, half of the teachers reported that they utilized selective grouping for projects and activities (i.e., grouped the student with peers she was comfortable with, allowed student to work in small groups or alone); 50% also reported that they were cognizant to increase expectations and goals relating to talking and communication behaviors once the child became more comfortable and demonstrated more challenging behaviors.

The following classroom modifications were implemented by 33.3% of the sample: teacher listening to or watching a tape of a student talking or singing at home (one was seen by the teacher with the student's knowledge and one without); incorporating formal group games during the school day to encourage peer interaction and spontaneous language; preferential seating in a place where the student appeared most comfortable (i.e., in front of teacher or to the side so as not to be directly surrounded by children); and providing warnings or preparation time for the student prior to asking her a question in the group situation and refraining from asking direct questions in a large group.

Seventeen percent of the participants reported implementing the following strategies: including the parent in classroom activities (i.e., morning routine, game playing) to ease transition for the child and encourage group participation; acknowledging feelings of nervousness of the student; assisting in organizational tasks (e.g., packing and unpacking book bag); using a blindfold during an individual lesson with a teacher to remove the pressure of eye contact; ensuring that all regularly used classroom materials were easily within reach of the student to lessen her need to ask for

assistance; and making concerted efforts to include the student in class discussions. Refer to Table 4 for a summary of teacher-developed modifications utilized.

While the above interventions or modifications are generally informal, four out of six teachers (66.7%) implemented more formalized cognitive behavioral techniques as advised by an outside professional/therapist working with the student. These included: use of a tape recording (33.3%) of the child talking at home that was then played for the teacher in school; recording and encouraging frequency of eye contact (16.7%); and the use of a "Selective Mutism workbook" (33.3%), which is a hierarchical intervention, created by Dr. Elise Shipon-Blum, a medical doctor and director of Selective Mutism Anxiety Research and Treatment Center (Smart Center). Specifically, this workbook charges the student in participating in simple nonverbal activities that then gradually become more difficult and require increased volume of speech and length of utterances, as well as a larger listening audience (e.g. nodding, answering scripted yes/no questions, answering open-ended short answer questions, engaging in dialogue to an individual then group). After each activity the student is asked to rate her level of nervousness.

Fifty percent of the teachers used formal measures to assess the efficacy of at least one intervention applied. This included a checklist to record frequency of eye contact with the teacher, as well as the use of the "Selective Mutism workbook," in which specific goals had to be met, through observable behaviors (e.g., nodding for yes or no; whispering the sounds of the alphabet) before proceeding on to more difficult tasks. Teachers regarded the strategies to which the students responded well as successful (i.e., student's nervousness appeared to decrease and/or student's talking behaviors or communication appeared to increase). Refer to Table 5 for a summary of cognitive behavioral based

interventions utilized by teachers.

Reportedly, strategies were consistently implemented by teachers, with the exception of those that required outside individuals or materials (i.e., parent's participation in the classroom, home video/tape) or detracted from teacher instruction (i.e., use of games). For those that required individual student attention (i.e., use of a specialized book), teachers in the collaborative team teaching setting noted the collaborative team teaching situation enabled one teacher to work privately with the student for three occasions. Subsequently, various other school staff members worked with the students for additional individual sessions.

Table 4

Teacher-Developed Modifications Utilized at Any Time During the School Year

Classroom Modification	**Percentage of Teachers**
Use of prompts, encouragement and individual attention (e.g., positive reinforcement, frequent check-ups to see if assistance was needed)	100%
Refrain from pressuring the student to talk (e.g., coercing, punishing, extensive praise for talking)	100%
Use of nonverbal means (e.g., sign language for bathroom or other needs, picture cards, use of own white board)	50%
Selective grouping for projects (e.g., group with peers that students are comfortable with, allow student to work in small groups or alone)	50%
Increase expectations and goal setting	50%
Listen or watch home tape of student talking or singing (1-with student's knowledge and 1- without student's knowledge)	33%
Use of games that encourage peer interaction and/or minimal rote speech	33%
Preferential seating for student	33%
Provide warning or preparation time prior to calling on the student	33%
Refrain from asking direct question in large groups	33%
Incorporate parent into classroom strategies (e.g., to assist child in transitioning to new class, parent slowly decreases involvement)	17%
Acknowledge feelings of nervousness	17%
Provide organizational skills with packing and unpacking materials	17%
Use of blindfold to remove the pressure for eye contact	17%
Instruct peers not to comment on student's talking behavior	17%
Make common classroom materials easily accessible and within reach of the student	17%
Ensure to include student in class discussions (e.g., by actively asking questions to this student, but not requiring a verbal response)	17%

Table 5

Cognitive-Behavioral Approaches Utilized at Any Time During the School Year

Cognitive-Behavioral Approach	**Percentage of Teachers**
Use of prompts, encouragement and individual attention (e.g., positive reinforcement, one-on-one implementation)	100%
Refrain from pressuring the student to talk (e.g., not coercing, punishing or providing extensive praise for talking)	100%
Use of successive approximations from nonverbal responses to small sounds to whisper to words with different individuals (e.g., nodding, yes/no questions, short answer questions, rehearsal)	33%
Use of a workbook, created by Dr. Shipon-Blum, completed with different school members with the student. This book introduced different speaking activities on a hierarchy.	33%
Rate level of nervousness before and after talking activities	17%
Encourage student-teacher communication via writing	17%
Increase eye contact via charting level of eye contact at baseline and after implementing prompts	17%

5)What are the challenges that teachers face, both personally and professionally in terms of teaching a child with selective mutism (e.g., lack of support, difficulty assessing student's academic skills)? How do teachers respond to these challenges? What resources do teachers report would benefit them in understanding, teaching and intervening with these students (e.g., training, consultation)?

The majority of the sample (80%) reported feeling some level of frustration or worry when teaching the child with selective mutism. A large portion (50%) of teachers reported that they were concerned about not being aware of the child's academic or emotional needs. Similarly 50% of participants were hesitant or unable to fully implement strategies targeted towards this one student (e.g., playing games, completing

the “selective mutism workbook”), due to time constraints and fear the possibility that special modifications may highlight and worsen the student’s issues. Thirty three percent complained of little or no guidance in developing interventions. This same percentage felt frustrated that parents did not appear to understand that progress would be slow, and thus expected too much from the teachers, in terms of completely and quickly treating their daughters.

All teachers, but Participant 3, expressed a desire for additional support or professional development. Participant 3 stated that she was satisfied with the support that she received from parents, school staff and an outside specialist; this specialist provided specific intervention materials (i.e., selective mutism workbook) that guided the teacher and school in implementing a manageable and successful program. All of those requesting additional information and training noted that training should not be provided to the teacher in isolation. Rather, they strongly expressed a wish to learn about this disorder in collaboration with others who interacted with the student, such as teachers and staff members (100%), as well as parents (40%). Sixty percent also desired the involvement of a school counselor or school psychologist.

Specific topics of interest that the teachers would like workshops to address included: which interventions are and are not effective (80%); a deeper understanding of the symptoms, causes and experience of the student with selective mutism (40%); the role of anxiety medications in treating selective mutism (20%); and the benefits of having the student switch schools or classes to allow a new beginning (20%).

The teachers also responded that they would have appreciated the following supports: opportunities to observe experienced individuals implementing strategies

(60%); an organized meeting in the beginning of the year to discuss target student's need and background information with all involved members (40%); more help in the classroom or school setting, e.g., paraprofessional or additional counseling, (40%); school-based consultation sessions to discuss the student's unique needs (40%); selective mutism resources, i.e., books, pamphlets, websites, access to experienced individuals, (40%); more positive feedback (20%); and additional communication technology devices, such as a laptop specifically for this student (20%).

Chapter 5

Discussion

This study set out to explore teachers' knowledge of selective mutism's diagnostic criteria, their use of interventions, and their desire for additional support, as well as the specific academic and behavioral presentation of their students with selective mutism. As no such previous studies exist, the purpose of this research is to investigate and develop ways to assist teachers in identifying and intervening with this population. Six teachers from four Manhattan public schools, with at least one year of experience teaching a student with selective mutism, participated in the individual phone interview process. Interview questions queried the following domains: (a) demographics of teachers and students; (b) teachers' knowledge of selective mutism; (c) the typical referral process for these children; (d) interventions that were most commonly employed in the classroom; (e) behavioral, academic and social presentation of the student at school and home; and (f) the needs of teacher in terms of additional support or professional development.

Teacher Knowledge of Selective Mutism

The current study surveyed teachers' knowledge of the symptoms outlined in DSM-IV TR for selective mutism. All teachers were able to identify a lack of talking behaviors in one setting and not another as a major indicator. However, none of the teachers stated the exclusionary symptoms of (a) the presence of another disorder or (b) the time frame that mutism must be present before a diagnosis can be determined.

Lack of knowledge regarding differential diagnosis can lead teachers and school staff to incorrectly assume that children who are presenting with other issues (e.g.,

adjusting to the school setting or cognitive deficits) are selectively mute; this is clearly a disservice to the child and family. For example, prematurely diagnosing a shy child who just began Kindergarten with selective mutism can trigger alarm for parents and teachers driving them to seek unnecessary services or evaluations when there is no cause for concern. Even worse, failing to recognize that in certain situations a lack of speech is due to cognitive impairments can have the opposite effect, as parents and teachers may neglect to seek enough help or assistance. Similarly, the research cautions against prematurely suspecting recent immigrant English language learners of selective mutism. Children usually present with a "silent period" when learning a second language (Toppelberg, Tabors, Coggins, Lum, & Burger, 2005). A teacher's misunderstanding and subsequent interference with this natural process can put unjustified strain on the child and family, impacting language and social development, as well as overall learning and comfort within the classroom setting.

Much of the current research strongly supports anxiety as the principle underlying cause of selective mutism (Bergman et al., 2002; Black & Uhde, 1992; Cohan et al., 2006; Dummit et al., 1996; Steinhausen et al., 2006). Yet, as this study indicates, only 50% of the teachers in this sample were aware of the predominant role of anxiety in this disorder. This raises concern that teachers who lack such knowledge may presume the child is choosing not to speak, rather being unable to express themselves due to anxiety. Such an erroneous belief can be detrimental to both teacher and student. The teacher is likely to become easily frustrated and impatient as he or she may employ counterproductive strategies, such as pressuring the child to speak or penalizing the student for lack of verbal participation. These methods are apt to exacerbate the student's

anxiety and damage the teacher-student relationship, setting the stage for a year-long power struggle.

Students' Behavioral, Academic and Social Presentation at School

The study also queried teachers about the academic, behavioral and social functioning of the target students. Consistent with previous research (American Psychiatric Association, 2000), the majority of students had presented with oppositional behaviors at home, in contrast to the school setting. Students were generally more comfortable around other children, rather than adults. In addition, co-morbid behaviors that are outlined in the DSM-IV-TR were exhibited by all of the participants. These include compulsive behaviors (i.e., perfectionism, eating issues, highly organized), shyness and social withdrawal. Regarding academic functioning, 80% of the children in this sample were identified as having special educational needs and services. Although the research differs in terms of understanding the cognitive potential of these students, it does hypothesize that many of these children suffer from academic issues due to mutism behavior, rather than intellectual deficits (Cunningham, McHolm, Boyle, & Patel, 2004; McInnes et al., 2004; Pionek-Stone, Kratochwill, Sladezcek, & Serlin, 2002). Findings also indentified distinctive behaviors that were not reported in the literature such as disorganization, poor motor skills, poor academic motivation and frequent lateness to school. Further research would be needed to determine whether these traits are common among those with selective mutism, or are just specific to individual children.

Referral and Background Information

As early identification and intervention are crucial in successfully treating selective mutism (Cohan et al., 2006; Schwartz & Shipon-Blum, 2005), referral

procedures and initial time of identification and intervention for this sample were explored. All teachers, except Teacher 2, believed that students were first identified and referred in Kindergarten with selective mutism. This is consistent with research, which states that symptoms are generally first identified when the child begins formal schooling (Black & Uhde, 1995; Steinhausen & Juzi, 1996). It is comforting to note that per teachers' reporting, students began receiving some form of intervention (e.g., via an IEP) soon after identification. No extended delay in this regards, as much of the existing research describes (Schwartz & Shipon-Blum, 2005), was mentioned by any of the teachers. Yet, since all students in the study were already identified with selective mutism, no information was gathered on the percentage of missed referrals, which according to research can be quite high (Cohan et al., 2006).

The middle school student (Student B) presented as a unique, somewhat puzzling, case in this study. This 13- year-old adolescent student (oldest in the sample), continued to present with acute symptoms of selective mutism and has only received minimal teacher intervention. Unlike all of the other students in the study, she was not classified with any special needs or services. On the contrary, Student B was enrolled in honors classes and was identified as a very bright and high achieving student.

Many questions beg for explanation in this unusual case. Yet, unfortunately few answers are available given the teacher's (Teacher 2) limited knowledge of the student's background. Specifically, it would be helpful to know whether the disorder was first recognized before or after the student's emigration from Europe and whether interventions were previously attempted. It is possible that since Student B was bright and functioning at or above grade level, interventions were not deemed necessary. In fact,

during the interview, Teacher 2 shared her conflicting feelings of wanting to help Student B, while at the same time was concerned with neglecting her main duty of educating her class. Teacher 2, unlike the elementary school teachers, was afraid that by focusing on an individual's emotional issues, the learning of the rest of the students would be compromised. (Yet, it is important to note that all of the other teachers had other adult support in the classroom lessening this concern.)

Record keeping in the child's cumulative file is also needed so that as the child progresses from grade to grade information can be shared with new teachers. Specifically, teachers should be made aware of when the child was referred, the intervention used, progress made and the students and school personnel to whom the child speaks. Such a tracking system will ensure that the child does not get lost in the system, that intervention continues and that teacher and school psychologist communication is fostered.

Classroom Interventions

Teachers were also asked to report on their use of interventions. Although, only two of the teachers received clear systematic interventions from an outside professional, all teachers attempted to incorporate classroom modifications that were supportive, rather than coercive, and that allowed for nonverbal communication. Many of the teachers intuitively developed and/or modified strategies that are described in the research for use in the classroom such as, using picture cards, refraining from pressuring the student to speak, listening to a tape of the student talking at home and/or incorporating the parent into classroom strategies to increase the child's comfort level (Cohan et al., 2006; Dow et al., 1995; Elizalde-Utnick, 2007; Krysanski, 2003; Schwartz & Shipon-Blum, 2005).

Although the majority of teachers did not have formal direction in intervening with the selectively mute student, all teachers reported an increase in the child's communication, whether verbal or nonverbal by the end of the school year. Several hypotheses can be garnered from the above. First, empathetic involvement of teachers appears to be a vital ingredient in assisting these students. Second, as found in research (Pionek-Stone and colleagues, 2002), the presence of an intervention or treatment is generally more crucial to success than the type of treatment utilized. Third, although teachers may have had difficulty stating the symptoms and cause of this disorder, many have an intuitive understanding of how to respond.

An interesting and unusual strategy used by one teacher, as advised by a speech therapist, was to use a blindfold on the student in an individual setting to remove the pressure of eye contact. Although, the teacher was unable to utilize this approach often, she believed that it helped to make the student less intimidated and more likely to communicate verbally. It would be interesting to study the effectiveness of this and other similar strategies (e.g., all students wearing sunglasses, playing a class game in the dark) on the selectively mute child’s level of anxiety and inhibition.

Feelings and Needs of Teachers

It was apparent and impressive that the teachers in this sample truly cared for and empathized with their students. The teachers understood that the students were not being oppositional, but were instead experiencing emotional distress. In fact, the single concern that most frustrated teachers was not being able to discern the needs or feelings of the student. Other areas of frustration included: feeling that there was insufficient progress

made regarding the child's talking behaviors, receiving little support or understanding from the school and/or parents, and having limited knowledge of the disorder.

All but one teacher, who received outside support and an explicit intervention plan from an outside professional, expressed a desire for more direction and information in regards to understanding selective mutism and applying interventions. The teachers specifically addressed the need for team consultations. Half of the sample explicitly expressed the desire for school psychologists to be involved with trainings and consultations. This is not surprising as school psychologists, with educational backgrounds in both academic and emotional arenas, are the ideal individuals to assist teachers in better understanding and intervening with selectively mute children. In fact New York City school psychologists are generally the first ones teachers approach when any referral is made. They are vital individuals in appropriately classifying a child and creating a quality and suitable Individual Education Plan (IEP).

Implications for School Psychologists

The information below although ideally intended for school psychologists, given their education and experience in a multitude of venues, can also be applied to the School Based Assessment Team and school guidance staff (e.g., school social worker, guidance counselors). In the New York City Department of Education, school psychologists are primarily expected to complete the special education process, which means evaluating, developing IEPs and chairing IEP meetings. Unfortunately, all of these responsibilities, in conjunction with their large caseloads and often limited time in a single school, detract from the school psychologist's ability to immerse him or herself in other, albeit important, ventures. Rather, it is the responsibility of the guidance counselors (and

sometimes social worker) to intervene with students that present with social-emotional challenges and to consult with their teachers. For the purpose of this study school psychologists are targeted, but once again, all guidance staff can fulfill the roles detailed below, with the exception of formal assessments.

Since only teachers were interviewed for this study, little is known about the knowledge, skills and attitudes of the school psychologists in regards to selective mutism. In fact, only one teacher mentioned that she consulted with the school psychologist and although the psychologist was able to provide emotional support, she had little to offer in regards to teaching such a student. Given their role in the referral, assessment and IEP process, it is crucial that school psychologists have an understanding of this disorder, as related to referral, creation of IEP goals, and implementation of feasible interventions in the classroom.

District or city wide trainings should be provided for school psychologists regardless of the current needs in the school. These workshops should focus on, recognizing symptoms of selective mutism, possible differential diagnoses, writing proper educational goals and implementing classroom strategies and ways to train parents and school providers in a collaborative manner, as well as the potential effectiveness of medication and proceeding with a medical referral. Through this cost effective and manageable training tactic, schools will be assured at least one member that can educate and guide the team working with such a child. As discussed, the only concern that may hinder this process is the lack of time, as school psychologists in the New York City Schools are often busy with evaluations and developing IEPs. Thus, collaboration with the guidance staff (i.e., the guidance counselor and social worker) is recommended to

divide tasks such as leading trainings, observing, consulting with teachers, and developing and supervising the implementation of interventions.

Knowledge. As mentioned previously, teachers may not be aware of all the symptoms of selective mutism, especially the exclusionary ones, or that this disorder is generally recognized as anxiety based. Given the potential problems resulting from this lack of knowledge, it is crucial that the school psychologist and guidance staff collect data and developmental history on the student and formally educate the teacher, parent and therapists of the child suspected with this disorder, before arriving at a conclusion. As teachers in this study requested, workshops or others resources such as pamphlets, written diagnostic criteria and websites should be provided for the teachers that address interventions that are and are not effective; a deeper understanding of the symptoms, causes and experience of the student with selective mutism and the role of anxiety medications in treating selective mutism.

The teachers also responded that they would have appreciated the following supports: opportunities to observe experienced individuals implementing strategies (60%); an organized meeting in the beginning of the year to discuss target student's need and background information with all involved members (40%); and more help in the classroom or school setting, e.g., paraprofessional or additional counseling, (40%).

Consultation. Trained in consultation methods, school psychologists are the ideal individuals to encourage and lead the collaborative process that teachers in this sample desired. An initial meeting to provide psychoeducation and engage in data collection should incorporate the whole treatment team within and outside the school setting, including parents and private professionals working with the student. This process will

allow a complete picture of behavioral and background information to be uniformly collected and shared, as well as foster collaboration and consistency, which are necessary components when dealing with such a child. Furthermore, such meetings would allow teachers to brainstorm and support one another, as needed, before becoming overly frustrated. Follow-up trainings, also provided in the collaborative manner, should focus on appropriate expectations for the student, how to recognize and encourage emotional expression, as well as specific classroom interventions and modifications to foster nonverbal, as well as verbal interaction with peers and teachers. Subsequent meetings are needed to support teachers, discuss progress, and determine the need for adaptations to current strategies depending on the students' response. With the proper training, school psychologists can also assist the teachers by modeling some classroom interventions and providing counseling for students with selective mutism.

Once a student is identified as potentially presenting with selective mutism, ongoing consultation between the school psychologist and teachers and other providers is advised to help teachers develop and utilize intervention strategies that can be easily implemented in the classroom, as well as provide a forum for discussion and support. Regular meetings will help to ensure treatment integrity and guide teachers on collecting data to assess whether intervention should be continued, streamlined, or modified.

These sessions also provide a forum to discuss the need for initiation or revision of special education services. In cases where a student may benefit from beginning special education services, the school psychologist is needed to comprehensively assess the student by first collecting data on the child's behaviors in different settings, by interviewing the parent and teacher and through a classroom observation. If, upon further

investigation, the student appears to be suffering from anxiety and/or selective mutism that is impacting his/her educational functioning, cognitive, academic and emotional testing should be completed, as well as a speech evaluation and referral for a psychiatric evaluation to assess possible need for medication.

Assessment. When completing the school assessment, it is recommended that the school psychologist first administer a nonthreatening nonverbal measure to help the student feel at ease such as the Bender. Regular IQ testing that includes verbal and nonverbal tasks can be quite informative in comparing the student's performance in both domains. However, it is crucial that weaknesses on nonverbal measures, which are likely due to a lack of speech and not skill or ability, be explicitly explained as such. If indeed the assessment process reveals impaired academic functioning, an IEP meeting is held to initiate special education services. Given the somewhat subjective nature of determining the negative effects of minimal or lack of speech on academics, especially in the younger grades, this decision may differ from school to school. Yet, in making this determination, it is vital that the team (e.g., school psychologist, teacher, principal, social worker, parent and speech therapist) consider the student's social and emotional functioning, as peer interaction and social adjustment are key elements of the educational process and contribute to academic success.

Individualized Educational Plans (IEP). Collaborative efforts between the teacher, parent, speech therapist and school psychologist are advised to develop an individualized educational program (e.g. that includes speech, counseling), attainable IEP goals and proper classroom modifications that address both the student's academic and emotional functioning and build upon the student's strengths. Goals may include:

increasing and initiating nonverbal communication with a peer and/or teacher during learning and social activities; asserting oneself by asking for needs through nonverbal means; increasing eye contact; participating by writing answers down or whispering to the teacher; and recognizing when he/she feels anxious and utilizing coping strategies. Of course goals should be updated regularly so expectations can become more complex and challenging as previous objectives are met.

Student needs/academic functioning. As discovered in this study, teachers are most concerned with not being able to discern student needs; classroom observations should be conducted by guidance staff, as well as social-emotional training to help teachers recognize the student's needs and encourage expression of feelings and foster peer interaction. The school psychologist can also collaborate with teachers to develop assessment methods that will accurately evaluate the student's academic functioning. In addition, the need for an assistive technology (e.g., personal laptop) should be considered by the team, to aid the student in verbalizing his/her needs through an intermediary devise or another child acting as the middle man. However, it should be noted that the research differs on the efficacy of such an intervention in light of the potential for the student to become too dependent on these devices. Others feel that for a child who desires to verbally communicate, but cannot due to anxiety, the use of picture cards and other nonverbal means will allow the student to participate, feel internally reinforced and included in the class. These positive feelings and regular interaction will pave the way for increased verbal interaction as the year progresses.

Attitudes

Given the potential and understandable frustration a teacher with a selectively mute student may experience, the school psychologist is needed to support and encourage the teacher. It is important that teachers understand that progress is often slow and minimal, especially in acute cases. Teachers, although as witnessed in this study are greatly empathic towards these students, also need a safe place to express their feelings and receive recognition for implementing classroom strategies and interventions with integrity, as well as maintaining a positive and accepting attitude. Also, parents and administrators often place unreasonable expectations on teachers to yield quick success in "curing" the child. Thus, school psychologists should also provide indirect support to teachers by ensuring that parents and others are aware of the expected rate of progress to reduce undue stress on teachers.

Limitations of the Study

Given the small sample size of six teachers, the results gathered here should be considered a limited representation of the teacher or student population regarding selective mutism. Furthermore, it is possible, based on the low participation rate that only those who experienced success agreed to participate. Another limitation is the specific geographical region, as all children are enrolled in New York City Public Schools in the borough of Manhattan, with only a restricted range of demographics and race for both teachers and students. At the same time, the actual number of youngsters diagnosed with SM is relatively small so sample sizes, generally speaking, are likely to be somewhat limited.

Information was gathered from teacher interviews and personal accounts, rather than through direct observation of the child by the researcher**.** Notably, teachers in this study were relied upon to report that a child was diagnosed with selective mutism; no medical documentation was available to confirm this diagnosis. Thus, subjectivity, inaccuracies or omissions were more likely. Additionally, teachers may have neglected to disclose mistakes they have made or to report the use of interventions that were not effective.

Another limitation of the study is the timing of the interviews. All interviews were administered over the summer outside the school setting. This means that all teacher participants had taught a student with selective mutism for at least one full year. While this research provides data for those with some experience teaching this population, it does not explore the needs and knowledge of teachers with little or no experience in regard to selective mutism. In addition, the timing of these interviews did not allow for access to school records (e.g., IEP, report cards) for verification of the student's educational history. Rather participants had to rely on memory, which may have led to inaccurate reporting.

Only data of previously referred children, still presenting with selective mutism, was collected. Thus teacher knowledge of the child's symptom presentation in earlier grades, including what occurred prior to and during referral, as well as the rate of success in terms of teacher/school intervention, was very limited or unavailable in this study. Further research would be needed to better understand these issues.

While most of the teachers taught the elementary grades, one participant taught at the middle school level, which posed some questions that were not able to be fully

explored in the current study. Namely, what is the teacher's role in providing support for academically competent students with emotional issues? In addition, how feasible is it for middle school teachers to supply the level of support that such a student requires? What specific factors contributed to Student B's acute and intractable form of selective mutism, lasting into middle school? Additional studies that investigate middle school teachers' attitudes and use of classroom interventions are needed to understand whether and needs of teachers at these grade levels differ from elementary school teachers.

Lastly, no pre and post data on talking the knowledge behaviors were available to analyze or review. For example, we do not know if the student achieved greater progress in talking behaviors from the previous year. Although all teachers stated that students were more responsive and expressive at the end as compared to the beginning of the school year, this is based on teacher observation and experience and not on hard data. In addition, it is possible that the students made similar progress in past grades but then regressed over the summer or when meeting a new unfamiliar teacher.

Despite the limitations of the study, findings indicate that teachers are generally sympathetic and appropriately responsive towards the student with selective mutism. Notably, even with little training and experience dealing with the selectively mute population, the teachers in this sample instinctively understood that these students thrive most when they are emotionally supported and not pressured to talk. Consistent with goals and interventions highlighted in the research, teachers tried various strategies to limit anxiety, build trust and increase nonverbal and verbal communication in a positive and encouraging manner. Teacher interventions produced some degree of increased communication and comfort for all students. However, teachers did not properly chart

their use of interventions or students' behavioral progress, making it difficult for the teachers and for this researcher to fully analyze intervention success and student progress. This may have contributed to regression or limited progress from one grade to the next, as observed in this study. In addition, teachers had limited knowledge of official symptoms and differential diagnoses for selective mutism, which likely increased their insecurity and self-doubt when incorporating interventions. The vast majority (83%) of the sample expressed a desire to learn more formal and organized approaches to better help the student with this disorder.

It is important to note that each student in this study, although diagnosed with the same disorder of selective mutism, presented with unique symptoms and a different behavioral picture in regards to communication, talking behavior, peer relationships and academic functioning. Given individual differences, it is difficult for an identical and uniform intervention plan to be implemented for all students. Rather teachers should receive support and guidance from a knowledgeable/trained individual that takes into account specific student characteristics and teacher needs. Thus, as stated previously, it is imperative that school psychologists and school guidance staff (e.g., school social worker, guidance counselors) are available and appropriately trained to guide teachers in developing, implementing and assessing outcomes of interventions individualized for the relevant student. It is hoped that employing such a collaborative process will provide teachers with the knowledge, support and confidence to best educate and encourage their students with selective mutism.

Based on the findings of this study, this researcher developed guidelines (see Appendix B) for school psychologists and school guidance staff to use in collaboration

with teachers to best support them in teaching a student with selective mutism. Materials included in this packet are intended to assist the school psychologist and teacher to (a) identify selective mutism symptoms, (b) engage in effective consultation, (c) increase home-school collaboration, (d) maintain better record keeping from grade to grade, (e) ensure proper data collection for interventions, (e) gather student input and (f) locate informational resources.

It is unsettling that, as current research shows, only about 60% of children with selective mutism receive prompt identification and intervention. This lag can have a serious impact on treatment outcomes. Yet, with proper knowledge and support, teachers and school personnel have the power to change that so that 'no child (with selective mutism) is left behind.'

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Appendix A

Semi-structured Interview for Teachers of Students with Selective Mutism

Teacher ID#: _____ Date of Interview:_____

School:_____

I. Demographics of Teachers

1) Years of teaching_____
2) Subjects/grade level taught_____
3) Education level_____
4) Number of students currently teaching with selective mutism_____
5) Number of students previously taught with selective mutism_____
6) Diagnoses of students previously taught

   _____

II. Demographics of Students

1) Age of student_____
2) Years with diagnosis/symptoms_____
3) Ethnicity of student_____
4) Language(s) spoken by student_____
5) Home Language_____
6) Health or medical status_____
7) Any Medications_____
8) Any identified language or learning issues (e.g., IEP)_____

   _____

9) Services provided inside or outside of school _____

_____

10) Who lives with student?_____

11) What is the student's relationship with his/her parents?

_____
_____

12) Family History of SM or other disorder?

_____
_____

III. Teacher knowledge of SM

1) From what you know, what are the typical symptoms or behaviors that may suggest SM?

_____
_____
_____
_____
_____

2) What do you feel is the underlying cause of SM?

_____
_____
_____
_____
_____

3) What strategies do you use in the classroom to help a student with SM?

_____
_____
_____
_____
_____

4) Were these strategies recommended by someone? By whom?

_____
_____
_____
_____
_____

5) When a student does not speak in your classroom, what are your immediate thoughts to explain this?

_____
_____
_____
_____
_____

6) What are some other possible explanations you have thought of to explain why a student will not speak in school?

_____
_____
_____
_____
_____

IV. Behavior of student

1) What behaviors and affect does this student display in the following settings/situations?
    a) Classroom

_____
_____
_____
_____
_____

b) Lunchroom

_____
_____
_____

c) Bus

_____
_____
_____

d) Playground

_____
_____
_____

e) Peers

_____
_____
_____

f) Teachers (classroom and other in various situations)

_____
_____
_____

g) Substitute

_____
_____
_____

h) Related service providers (e.g., speech teacher, counselor)

_____
_____
_____

i) Others (principal, parent on school grounds)

_____
_____
_____

2) Does this student exhibit any odd mannerisms, behaviors or habits? Explain when and where they occur.

_____
_____
_____
_____
_____

3) Does this student exhibit any conduct or aggressive behavior problems? Explain.

_____
_____
_____
_____
_____

4) How does this student communicate in the classroom (e.g., in response to questions or lessons, to express their needs)?

_____
_____
_____
_____
_____

5) Describe the student's self-help skills. Does the student care for his/her needs and work independently?

_____
_____
_____
_____
_____

6) What is this student's behavior like during transitions?

_____
_____
_____
_____
_____

7) How would you describe this student's academic skills, as well as motivation and attention?

_____
_____
_____
_____
_____

8) How do you know that the student is doing well, academically? How do you assess this, specifically their oral reading skills?

_____
_____
_____
_____
_____

9) In your observations, how do peers perceive and act towards this student?

_____
_____
_____
_____
_____

10) How does the student's parent describe his/her child's behavior at home?

_____
_____
_____
_____
_____

V. Referral Process

1) In your experience, what are some indications that you need to refer a student?

_____
_____
_____
_____
_____

2) To whom do you speak to make a referral?

_____
_____
_____
_____
_____

3) How long did it take for this student to be referred once it was suspected that there might be a problem? Days? Weeks? Months? If there was a delay, why?

_____
_____
_____
_____
_____

4) If you were the one who made the referral, did you have any reservations referring the student? What were they?

_____
_____
_____
_____
_____

5) When was this student officially diagnosed as having SM? By whom?

_____
_____
_____
_____
_____

6) How were you notified about this diagnosis?

_____
_____
_____
_____
_____

7) What was your initial reaction upon being informed that you have a student with selective mutism?

_____
_____
_____
_____
_____

VI. Consultation with others

1) Is there someone inside and/or outside the school with whom you can consult? Why this person? Was he/she helpful? Describe discussions.

_____
_____
_____
_____
_____

2) Describe your contact with the parents in terms of frequency, content and degree of helpfulness.

_____
_____
_____
_____
_____

3) Did you consult with the student's past teacher(s)? Was it helpful?

_____
_____
_____
_____
_____

VII. Classroom Interventions/ strategies

1) What accommodations and strategies have you attempted? For how long?

_____
_____
_____
_____
_____

2) Were you able to implement these strategies consistently? Why or why not?

_____
_____
_____
_____
_____

3) What has been successful and what has not been successful?

_____
_____
_____
_____
_____

4) What strategies have been suggested that you have not attempted? Why not?

_____
_____
_____
_____
_____

5) What are some challenges you face in terms of interventions (e.g., frustration, lack of time/support, not effective, not monitored)?

_____
_____
_____
_____
_____

6) Do you have any concerns with implementing strategies for this student?

_____
_____
_____
_____
_____

7) What interventions/issues have not been addressed that you feel is very important to helping you and the student?

_____
_____
_____
_____
_____

8) Are there more strategies that you would like to learn about? Explain.

_____
_____
_____
_____
_____

9) What supports would be helpful to you in learning and implementing more strategies?

_____
_____
_____
_____
_____

VIII. Needs of Teacher

1) What are some of your concerns with teaching this student with selective mutism?

_____
_____
_____
_____
_____

2) What would assist you best to address your above concerns?

_____
_____
_____
_____
_____

3) What are some of your personal frustrations/feelings in teaching a student with SM?

_____
_____
_____
_____
_____

4) What would be helpful to you to address the above?

_____
_____
_____
_____
_____

5) Would you like further support or training in this area? Explain what you would like to know.

_____
_____
_____
_____
_____

6) In what format would you like to receive this training (e.g., web seminar, school/district wide seminar, hand-outs, observation by school personnel)?

_____
_____
_____
_____
_____

7) Who, if anyone, in your school do you feel is best able to help you?

_____
_____
_____

8) Is there anything that you would like to add?

_____

_____

_____

_____

Appendix B

Selective Mutism Packet for School Psychologists, Guidance Staff and Teachers

The following materials were developed based on the dissertation study. Findings of the present study demonstrated a need for (a) increased collaboration between school psychologists and teachers, (b) assistance for both teacher and school psychologists in identification of the disorder, (c) regularly scheduled consultation sessions between teachers, school psychologists and parents, (d) increased teacher support, and (e) improved methods of data collection and record keeping.

To address these issues, the packet includes various materials that provide general guidance for school psychologists, teachers, parent and student. The specific uses and objectives for each form are detailed on the table of contents below.

Selective Mutism Materials

For School Psychologists and Teachers

Developed by Malkie Davidson

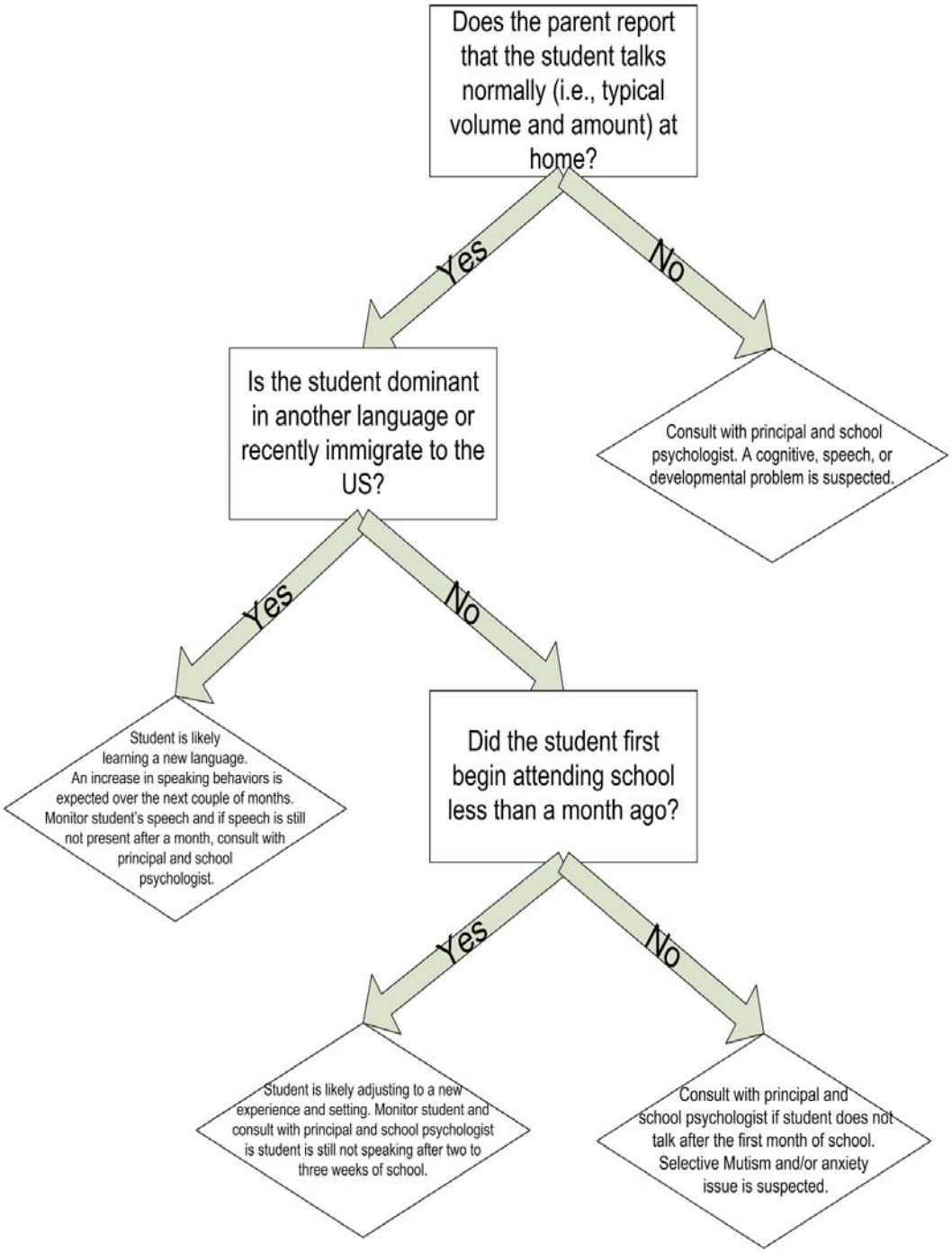
Table of Contents

B9-SM Form: End-of-Year Record for School File

This teacher form is to be completed at the end of the year. Information will allow for better history keeping and communication between teachers from year to year so that: (a) continuity of effective interventions can be maintained, (b) student comfort and progress is maximized, and (c) regression of mastered behaviors is limited.

B1-SM Form

Guide for Teachers
Assessing a Student Who Does Not Talk or Talks Minimally in School



B2-SM Form

Resources

Information Websites for teachers/parents (and students):
www.selectivemutism.org/
www.asha.org/public/speech/disorders/selectivemutism.htm
www.selectivemutismfoundation.org/
http://www.selective-mutism.com/
www.youtube.com/watch?v=IuN1iPiWP7o

Websites for Students
http://www.shykids.com
www.youtube.com/watch?v=IuN1iPiWP7o

Selective Mutism Treatment Centers
http://www.selectivemutismcenter.org/
http://www.aboutourkids.org/families/patient_care/child_family_associates/selective_mutism

Support Groups
http://health.groups.yahoo.com/group/Selectivemutismsupportgroup/
http://health.groups.yahoo.com/group/k12academics-selective-mutism/
http://www.selectivemutism.org/find-help/support-groups-by-state
http://www.experienceproject.com/groups/Have-Selective-Mutism/99561
http://www.selective-mutism.com/

Books for Parents/Teachers:

McHolm, A., Cunningham, C. E., & Vanier, M. K. (2005). *Helping your child with selective mutism.* Oakland, CA: New Harbinger Publications.

Shipon-Blum, E. (2003). *The ideal classroom setting for the selectively mute child.* Pennsylvania, PA: Selective Mutism Anxiety Research and Treatment Center.

Workbooks for children

Huebner, D. (2005). *What to do when you worry too much: A kid's guide to overcoming anxiety*. Washington, DC: Magination Press.

Buron, K. D. (2006). *When my worries get too big! A relaxation book for children who live with anxiety*. Overland Park, KS: Autism Asperger Publishing Company.

B3-SM Form

Teacher Consultation Needs

Dear Teacher,

We would like to support you in working with your student who has been identified with selective mutism. Research indicates that selective mutism is an anxiety disorder that impacts a child's ability to talk in certain settings, such as school, although he or she talks normally at home. Interventions are aimed at decreasing anxiety and increasing comfort so that the student can begin to connect and communicate nonverbally with peers and teachers. Consultation is an essential component to help this student. Please complete the following questions below so we can best arrange these sessions in a manner that is most helpful to you. See the attached list of selective mutism resources for information to help you better understand this anxiety disorder.

1) Who would you like present at these meetings (circle all that apply)?
   1) Parent
   2) Therapists (specify:_____)
   3) Other Teachers (specify:_____)
   4) School psychologist
   5) Guidance counselor
   6) Principal
   7) Other _____

I. What are some things you want to discuss? (circle all that apply)
   5) Background information of student (Specify:_____)
   6) Symptoms and presentation of disorder(Specify:_____)
   7) Interventions (Specify:_____)
   8) Peer relations (Specify:_____)
   9) Educational needs (Specify:_____)
   10) Other_____

1) Do you have prior experience working with children diagnosed with selective mutism or an anxiety disorder?
   1) Yes
      Explain:_____
      _____
      _____
   2) No
      _____

2) What are your goals in working with this student?

_____
_____
_____
_____
_____

3) What are your concerns in working with this student?

_____
_____
_____
_____
_____

4) We are aiming to meet once a month, but more support may be needed in the beginning of the year. How often would you like to schedule these sessions initially?

___weekly
___twice monthly
___monthly

5) Provide some times/days in the week when you are available

_____
_____
_____
_____

6) To make the most of our sessions, please include what has or has not been helpful in the past when consulting with school/parents.

_____
_____
_____
_____
_____
_____

9) What other supports would be helpful to you in working with this student?

_____
_____
_____
_____
_____

10) Please include any questions or comments that you may have:

_____
_____
_____
_____
_____

B4-SM Form

Consultation Session Notes

Today's Date:_____

Date of last consultation session:_____ Date and time of next consultation session_____

Name of person/people completing form:_____

Attendees _____ _____

_____ _____

_____ _____

_____ _____

Summary of topics covered:

_____

_____

_____

_____

Was student progress noted from last session? Explain.

_____

_____

_____

_____

Teacher concerns:

_____

_____

_____

_____

_____

Parent concerns:

_____

_____

_____

_____

_____

Interventions that will be tried/continued in classroom

Intervention description	Expected behavioral changes	Person responsible to implement intervention	Times and frequency intervention will be applied	Method of data collection

Suggestions to try at home (e.g., invite a friend, place an order at a restaurant,)

_____
_____
_____
_____
_____

Ways to improve home-school collaboration:

_____
_____
_____
_____
_____

Topics to be covered in the next consultation session:

_____
_____
_____
_____
_____

Materials/individuals needed for next consultation session (e.g., Data Collection form):

_____
_____
_____
_____
_____

What did you find most helpful during this session?

_____
_____
_____
_____
_____

What changes would you make so our following sessions are more helpful?

_____
_____
_____
_____
_____

B5-SM Form

Parent Needs

Dear Parent,

We would like to get your input so we can best work with you and your child. Selective mutism is an anxiety disorder that affects your child's ability to talk in certain settings, such as at school, although he or she talks normally at home. Interventions are aimed at decreasing your child's anxiety and increasing comfort so that your child can begin to connect and communicate nonverbally with his/her peers and teachers. Home-school collaboration is an essential component to helping your child. Please complete the questions below so we can gain a better understanding of your child and develop an intervention plan to maximize his/her success at school.

1. Explain your child's speech and mood at home (with and without non-family members).
   _____
   _____
   _____
   _____
   _____

2. What are some of your child's strengths?
   _____
   _____
   _____
   _____
   _____

3. What are some of your child's interests?
   _____
   _____
   _____
   _____
   _____

4. Does your child fluently speak another language besides English? Which language is spoken at home?
   _____
   _____
   _____
   _____
   _____

5) Does your child have any speech or language issues at home (e.g., stutter, lisp, difficulty finding the right words to express himself or herself, or difficulty understanding others)?

_____
_____
_____
_____
_____

6) When did you first notice that your child had symptoms of selective mutism (i.e., very shy, wasn't comfortable in certain situations)?

_____
_____
_____
_____
_____

7) When was selective mutism first diagnosed and by whom?

_____
_____
_____
_____
_____

8) Is there a family history of selective mutism or anxiety disorder? Explain.

_____
_____
_____
_____
_____

9) What other supports or interventions, if any, are you/child receiving or have you/child received in the past to treat selective mutism?

_____
_____
_____
_____
_____

10) Which of the support services or interventions has or has not been helpful?

_____
_____
_____
_____
_____

11) What situations make your child most anxious and/or shy?

_____
_____
_____
_____
_____

12) In your experience, what helps to lessen some of your child's anxiety in these settings?

_____
_____
_____
_____

13) We would like to meet with you several times during the year to ensure proper home-school collaboration to maximize success. Besides for the classroom teacher, who do you feel should be present at these meetings. (circle all that apply)

- *Therapists (specify:_____)*
- *Other Teachers (specify:_____)*
- *School psychologist*
- *Guidance counselor*
- *Principal*
- *Other* _____

14) What are some of the things you would like to discuss? (circle all that apply)

2) Background information (Specify):_____
3) Symptoms and presentation of disorder(Specify):_____
4) School Interventions (Specify):_____
5) Peer relationships (Specify):_____
6) Education needs (Specify):_____
7) *Other*_____

15) What are some of your goals for your child this year in school?

_____
_____
_____
_____
_____

16) What are some of your concerns?

_____
_____
_____
_____
_____

17) To make the most of our sessions, please include what has or has not been helpful in the past when consulting with the school/other professionals.

_____
_____
_____
_____
_____

18) Please include any questions or comments that you may have:

_____
_____
_____
_____
_____

B6-SM Form

Data Collection

Teacher Review of Applied Intervention

Date:_____

Description of
Intervention_____
_____

Date Intervention began_____

This is the _____ number week the intervention is being applied.

Target behavior (what behavior(s) is expected and with what frequency or percentage)
_____
_____

How often was the intervention applied during the past week?
_____
_____
_____

Was there anything that impeded you from applying the intervention consistently (e.g., limited time or teacher support, too complicated for the classroom)?

_____
_____
_____

What do you need in order to be able to consistently apply the intervention?

_____
_____
_____
_____

What changes, if any, did you make to the intervention and why?

_____
_____
_____
_____

What behavioral changes did you note in the student in the past week?

_____
_____
_____
_____

Please attach frequency chart (Form 7) from the past week.

B7-SM Form

Data Collection - Frequency Chart

Date:_____

Target Intervention (e.g., asking the student yes or no questions)_____

Date Intervention began_____

Target behavior observing (e.g., nonverbal responses to questions)_____

This is the _____ (*number)* week this intervention was applied.

8) - Each time student demonstrated target behavior

a) - Each time student did not demonstrate target behavior

	Mon	Tues	Wed	Thursday	Fri
1st period					
2nd period					
3rd period					
4th period					
5th period					
6th period					
7th period					
8th period					
Total					

Do you notice any behavioral patterns during the day or week (i.e., more behaviors during certain periods, activities, or with certain teachers)?

_____

_____

Did student reach his/her behavior goals or expected level of performance?_____

B8-SM Form

Student Questionnaire/Interview

(Note to the school psychologist/teacher: This questionnaire is a template that may need to be revised depending on the child's age and needs. Given that the child is unlikely to talk, he or she can draw or write responses or complete this form with his/her parent at home.)

Dear Student,

Every child has something that makes them uncomfortable, that is hard or even scary for them. For some kids, being around a lot of people or strangers can make them anxious, very shy, and unable to talk. We know that you may want to talk but feel like you can't in some places. This is okay – you do not have to talk until you are ready. We would like to try to help you feel more comfortable in school so you are able to do your best work, have friends, and enjoy school. These questions will help us learn how we help you feel more comfortable.

1) What are your favorite subjects or things to do in school? (circle all that apply)

2) Reading
3) Writing
4) Math
5) Gym
6) Art
7) Playing board games with friends
8) Playing pretend or made-up games with friends
9) Playing sports or running types of games with friends
10) Playing by myself
11) Eating lunch
12) Other:: _____

2) What are your least favorite subjects or things to do in school? (circle all that apply)

- Reading
- Writing
- Math
- Gym
- Art
- Playing board games with friends
- Playing pretend or made-up games with friends
- Playing sports or running types of games with friends

- Playing by myself
- Eating lunch
- Other: _____

3) Do you feel more comfortable when you are at home? Do you do different things at home? Explain.

_____
_____
_____
_____

4) List some hobbies, interests or talents you have.

_____
_____
_____
_____

5) When do you feel the most uncomfortable or shy in school (and with what people)? Circle all that apply.

3) With some kids in my class
4) With all kids in my class
5) With kids that I don't know
6) With some teachers or therapists
7) With all teachers and therapists
8) With new people that I just meet
9) During loud times like lunch or recess
10) During certain subjects that I don't like or are too hard (which ones?_____)
11) I feel uncomfortable with everyone at school
12) Other

_____

6) Who do you talk to the most at school? Who do you feel the most comfortable with?

_____
_____
_____
_____

7) Do you feel like you have enough friends? If not, what would you like to do about it?

_____
_____
_____
_____

8) Would you like to talk more in school? To whom? Where?

_____
_____
_____
_____

9) What kind of help or way to express yourself would help you feel more comfortable?
    1) A buddy to help you with things when you are unable to talk
    2) Time to work with the teacher in a small group
    3) Work alone with a therapist (counselor or speech therapist)
    4) Work in therapy with a couple of other kids
    5) Play class games that don't require talking
    6) Respond to yes or no questions by nodding
    7) Say yes or no to questions
    8) Answer by writing down
    9) Answer by whispering
    10) Talk on a tape at home for the teacher
    11) Earn points or prizes for communicating
    12) Other: _____

10) What do you wish that other kids and teachers would understand about how you feel when you talk?

_____
_____
_____
_____

11) What else do you want people to know about you that they may not know?

_____
_____
_____
_____

B9-SM Form

End-of-Year Record for Student File

*Name of Student*_____
*Name of Teacher*_____
*Grade*_____

*Student first began showing symptoms of selective mutism (*i.e., no or minimal speech in the classroom but typical speech at home) in the _____ grade

Does the student have an IEP? _____

If yes, since what grade: _____

*Classification:*_____

*Class program:*_____

*Related Services:*_____ _____

_____ _____

1) Student began the year with these behaviors in my classroom:

_____
_____
_____
_____
_____

2) The following school interventions were tried:

_____
_____
_____
_____
_____

3) The following interventions were effective (explain):

_____
_____
_____
_____
_____

4) The following interventions were not effective (explain):

_____
_____
_____
_____
_____

5) These out-of-school strategies were tried:

_____
_____
_____
_____
_____

6) Specify the academic strengths and weaknesses of the student

Grade levels in reading _____, writing _____, math_____

_____
_____
_____
_____
_____

7) Resources and people I found the most helpful were:

_____
_____
_____
_____
_____

8) My advice to the upcoming teacher regarding the following areas :

a) Interventions

_____
_____
_____
_____
_____
_____

b) Classroom modifications

_____
_____
_____
_____
_____

c) Academic/reading assessment

_____
_____
_____
_____

d) Classroom participation

_____
_____
_____
_____

e) Peer/teacher interaction (include any children that the student whispers to or feels more comfortable around)

_____
_____
_____
_____

f) Parent communication

_____
_____
_____
_____