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# SELECTIVE MUTISM: A PRIMER FOR PARENTS AND EDUCATORS

By Thomas J. Kehle, PhD, Melissa A. Bray, PhD, NCSP, University of Connecticut; &  
Lea A. Theodore, PhD, Hofstra University

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Selective mutism is a rare disorder primarily characterized by the child controlling where, or to whom, he or she chooses to speak. It affects fewer than 1% of the population and appears slightly more often among girls than among boys.

Selective mutism typically is first observed when children start school. For a formal diagnosis of selective mutism there must be a consistent failure to speak in specific social situations for more than 1 month and evidence that the failure to speak is not due to lack of knowledge of spoken language or a communication disorder.

Children diagnosed with selective mutism tend to become increasingly more resistant to requests for verbal communication if the condition is left untreated. Lack of verbal communication, particularly in school settings, interferes with both class work and social interactions. Therefore, it is important that parents and educators understand and help children with selective mutism as early as possible.

## Characteristics

Children with selective mutism do not speak in specific situations, such as the school, although they do speak in other settings. Often in the settings where they choose not to speak they communicate by gesturing, pulling, or pushing or, in some instances, by using restricted speech consisting of single words.

Other associated features and disorders that may or may not occur include excessive shyness, depression, social isolation, withdrawal, negativism, clinging, tantrumming, anxiety, enuresis, vomiting, compulsive behavior, and controlling and oppositional behaviors, which may be more prevalent in the home setting. Often, these associated features are only present in the setting where the selective mutism occurs. For example, a child with selective mutism may also exhibit extreme shyness and considerable anxiety in the school setting, but not so in the home setting. The discriminations children with selective mutism make can be complex and almost defy explanation.

For example, one child diagnosed with selective mutism did not talk to her father or any of the male relatives on the father's side of the family. Around these relatives she also appeared anxious and depressed. However, she freely conversed with all of the males on her mother's side of the family and appeared happy, cheerful, and outgoing. Another extreme example is an adolescent who chose to talk only with her mother while the mother prepared dinner. Another child, a 10-year-old who was selectively mute, also exhibited enuresis (wetting) at school. However, after the selective mutism was successfully treated, her enuresis immediately ceased. It is not uncommon for these associated features to quickly lessen or disappear shortly after the child's selective mutism is successfully addressed.

## Development

There are various theories for why some children become selectively mute. Although past explanations of selective mutism have been based on psychoanalytic theory, this is no longer considered valid, and interventions based on this theory have been shown to be ineffective.

Learning theory explains selective mutism as a *learned response* that is subsequently reinforced and maintained by the child's social environment. However, the specific point where the child learns that not talking is, from the child's perspective, more adaptive than talking typically is unclear. Most likely, the reason that selective mutism is so difficult to remediate is that the children are often negatively reinforced for not speaking. For example, if the teacher notices that requests to the child to talk are distressful, the requests are often withdrawn. Consequently, the child learns *not* to speak. Classmates may then further exacerbate the child's selective mutism by communicating and interpreting the child's needs, thus reducing the need for the child to speak.

## Intervention

Most successful treatments for selective mutism are based on learning and behavior therapies that include reinforcement, modeling, stimulus fading, shaping, or a combination of these strategies.

**Self-modeling.** Self-modeling, in combination with several behavioral therapy techniques, has been remarkably successful. This is a cognitive-behavioral approach involving making an edited videotape that depicts the child supposedly verbally responding to the teacher's requests. However, the child in reality has been taped responding to *parental* requests for verbal responses. The edited videotape is shown to the child in school on several occasions. Various learning and behavioral strategies can accompany the self-modeling intervention, such as allowing the child to stop the videotape whenever the child sees himself or herself talking. At this point, the child is allowed to select a small gift-wrapped reward. The videotape is then shown to the child's classmates to promote peer expectations for appropriate speech. Other cognitive behavioral approaches involve the teacher and parents using frequent praise to promote the gradual and increasing use of speech. It is generally recommended that *any* attempts at verbal communication be reinforced (e.g., praise for audible whispers).

**Fading.** Fading involves placing the child in a social setting that requires speech, maybe playing Monopoly after school. The other players are individuals that the child readily speaks to, such as family members. Subsequently, classmates who have volunteered to stay after school and with whom the child does not speak are gradually introduced to the game. Consequently, the discrimination between those individuals to whom the child does or does not speak is *faded*. The fading technique can be easily applied in other settings as well, such as taking the child to a highly desirable restaurant where the child typically exhibits normal speech. During the meal, other children with whom the child was previously mute are gradually introduced into this comfortable situation.

**Successive approximation.** Normal speech can be promoted by the teacher by rewarding *small increments* toward achieving conversational speech. For example, the teacher at first rewards the child's written response only if the child also makes some noise. Following this, rewards are given if the child makes the noise only. This can be subsequently shaped to humming, repeating letters, reading small phrases, and, eventually, to normal speech.

**Mystery motivator.** A very economical intervention is using a *mystery motivator*, or simply keeping the reward for appropriate verbal speech unknown to the child. This tends to heighten the value of the reward, similar to that of a wrapped birthday present. The

teacher simply inserts a picture or description of the reward in an envelope and writes the child's name prominently and a question mark on the outside of the envelope. The envelope is then clearly displayed on the bulletin board. The classmates are introduced to the mystery motivator and told that it is a gift for the child with selective mutism once the child talks in class.

**Parent involvement.** Parents can assist teachers in implementing classroom-based interventions designed for their child. They can parallel teacher attempts at remediation by ignoring their child's attempts to non-verbally communicate and by not interpreting the child's needs to others. Conversely, if the child does speak in unexpected settings, or with unexpected individuals, the verbal behavior should be rewarded.

**Medication.** Medication should only be considered when behavioral interventions alone have not proven successful and should be prescribed under conditions of very careful monitoring of possible side effects by the physician. Parents should be aware that many medications have not been specifically approved for use with children and may have undesirable, even dangerous side effects for some.

Given these cautions, fluoxetine, or Prozac, is an antidepressant medication that has been shown to be quite beneficial in treating selective mutism, particularly when combined with other learning or behaviorally based therapies. In most, if not all cases, the medication can be discontinued after the child begins normal speaking because the child's speaking will be maintained by reinforcement in the natural environment.

## Resources

- Kehle, T. J., Madaus, M. M. R., Baratta, V. S., & Bray, M. A. (1998). Augmented self-modeling as a treatment for children with selective mutism. *Journal of School Psychology, 36*(3), 377–399.
- Rhode, G., Jenson, W. R., & Reavis, H. K. (1993). *The tough kid book: Practical classroom management strategies*. Longmont, CO: Sopris West, Inc. ISBN: 0944584543.
- Shipon-Blum, E. (2003). *Easing school jitters for the selectively mute child*. Meadowbrook, PA: Selective Mutism Anxiety Research and Treatment Center. ISBN: 097148001X.
- Shipon-Blum, E. (2003). *Understanding Katie*. Meadowbrook, PA: Selective Mutism Anxiety Research and Treatment Center. ISBN: 0971480036
- A hands-on storybook written especially for children between the ages of 3–12 who suffer from selective mutism and/or social phobia.
- Shipon-Blum, E. (2003). *The ideal classroom setting for the selectively mute child*. Meadowbrook, PA:

## Website

Child Anxiety Network. Division on selective mutism and  
childhood anxiety disorders—  
[www.selectivemutism.org](http://www.selectivemutism.org)

*Thomas J. Kehle, PhD, is a Professor and Director in the School Psychology program at the University of Connecticut and licensed as a psychologist in Connecticut, Utah, and Ohio. Melissa A. Bray, PhD, NCSP, is an Associate Professor of School Psychology at the University of Connecticut, a licensed psychologist, and a licensed speech-language pathologist in Connecticut. Lea A. Theodore, PhD, is an Assistant Professor of School Psychology at Hofstra University in New York City and is a certified school psychologist in New York and Connecticut.*

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The National Association of School Psychologists (NASP) offers a wide variety of free or low cost online resources to parents, teachers, and others working with children and youth through the NASP website [www.nasponline.org](http://www.nasponline.org)

and the NASP Center for Children & Families website [www.naspcenter.org](http://www.naspcenter.org). Or use the direct links below to access information that can help you improve outcomes for the children and youth in your care.

**About School Psychology**—Downloadable brochures, FAQs, and facts about training, practice, and career choices for the profession.

[www.nasponline.org/about\\_nasp/spsych.html](http://www.nasponline.org/about_nasp/spsych.html)

**Crisis Resources**—Handouts, fact sheets, and links regarding crisis prevention/intervention, coping with trauma, suicide prevention, and school safety.

[www.nasponline.org/crisisresources](http://www.nasponline.org/crisisresources)

**Culturally Competent Practice**—Materials and resources promoting culturally competent assessment and intervention, minority recruitment, and issues related to cultural diversity and tolerance.

[www.nasponline.org/culturalcompetence](http://www.nasponline.org/culturalcompetence)

**En Español**—Parent handouts and materials translated into Spanish. [www.naspcenter.org/espanol/](http://www.naspcenter.org/espanol/)

**IDEA Information**—Information, resources, and advocacy tools regarding IDEA policy and practical implementation. [www.nasponline.org/advocacy/IDEAinformation.html](http://www.nasponline.org/advocacy/IDEAinformation.html)

**Information for Educators**—Handouts, articles, and other resources on a variety of topics.

[www.naspcenter.org/teachers/teachers.html](http://www.naspcenter.org/teachers/teachers.html)

**Information for Parents**—Handouts and other resources a variety of topics.

[www.naspcenter.org/parents/parents.html](http://www.naspcenter.org/parents/parents.html)

**Links to State Associations**—Easy access to state association websites.

[www.nasponline.org/information/links\\_state\\_orgs.html](http://www.nasponline.org/information/links_state_orgs.html)

**NASP Books & Publications Store**—Review tables of contents and chapters of NASP bestsellers.

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**Position Papers**—Official NASP policy positions on key issues.

[www.nasponline.org/information/position\\_paper.html](http://www.nasponline.org/information/position_paper.html)

**Success in School/Skills for Life**—Parent handouts that can be posted on your school's website.

[www.naspcenter.org/resourcekit](http://www.naspcenter.org/resourcekit)

