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Supporting Children with Selective Mutism in Early Childhood Education Classrooms

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Submitted in Partial Completion of the
Requirements for Commonwealth Honors in Early Childhood Education

Bridgewater State University

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Supporting Children with Selective Mutism in Early Childhood Education Classrooms

"The words just don't come out". "I have what I'd like to say in my head, and sometimes I know the answer in class before anyone else; but I just can't speak out". "If I'm at home with my parents and close family, I'm fine, and you wouldn't think I had any problem. But if we go out and other people are around – or people I don't know well come to my home – I get anxious and the words can't come out. Its' worst when I am at school because it's full of people I don't know well". "Sometimes grown-ups, and children, think that I do it on purpose – that I am choosing not to talk. I think they think I want to be difficult or get back at them or something. It's not at all like that". "I feel scared". Each of these quotes were said by someone who has experienced selective mutism (Blum, 2013; Johnson, 2012).

Selective mutism is an anxiety disorder defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-IV) as "a consistent failure to speak in specific social situations (in which there is an expectation for speaking e.g., at school) despite speaking in other situations. The disturbance interferes with educational or occupational achievement or with social communication. The duration of the disturbance is at least 1 month (not limited to the first month of school). The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation, the disturbance is not better accounted for by a communication disorder (e.g., stuttering) and does not occur exclusively during the course of pervasive developmental disorder, schizophrenia, or other psychotic disorders" (Sanetti & Luiselli, 2009). In the past, selective mutism was called elective mutism, but according to Richard (2011), this was changed because the "individual has not elected to withhold the ability to talk in all situations; rather, the individual selects the situation and people with whom they verbally communicate (Richard, 2011).

Selective mutism is the most misdiagnosed, mismanaged, and mistreated anxiety disorder due to a lack of awareness and inaccurate and misleading information (Blum 2007). When people are exposed to someone who has selective mutism, they often interpret it as a refusal to speak, and as the child being defiant, controlling or manipulative (Crundwell, 2006). "The child is just being stubborn and controlling by not talking" (Blum 2007). But this is not the case; children with selective mutism have a severe level of anxiety that prevents them from speaking.

Selective mutism is also misinterpreted and misdiagnosed as autism, trauma, a second language barrier, another social anxiety disorder, (Child Mind Institute, 2022) or a language/speech delay. People will say "Children who are mute must have been traumatized", "Don't worry, it's just shyness that they will outgrow", and "If the child does not speak, they must have a language or speech delay" (Selective Mutism Foundation, n.d.). Due to these myths and the lack of awareness of selective mutism, the anxiety disorder "often persists and intensifies until the child is either seen correctly and receives proper treatment, or anxiety persists and ramifications of untreated anxiety prevail." (Blum 2007).

One of the most common misconceptions about a child with selective mutism (besides defiance) is that they are just shy. People with selective mutism present with a lack of speech in specific settings/situations and commonly will not warm up to situations after a significant amount of time. They have an impairment in functioning in school, in the community, and/or at home due to their lack of speech behavior. People with selective mutism often have fewer friends than most of their peers and may not speak to anyone or only speak to particular people in school for several years. When asked a question, children with selective mutism may stare or look, act or be frozen, and they may use nonverbal communication strategies to get their needs met. People who are shy may speak in all settings, even if it is quiet or limited. Despite being slow to

warm up, children who are shy are still able to function and develop relationships in school, in the community and at home after a short period of time has elapsed. Eventually they will be able to interact both verbally and nonverbally people in particular settings. People who are shy will have a similar number of friends to those of their peers. They do speak in school settings, even if it is only to a select few peers and staff members (Kovac & Furr, 2019).

Causes

There is no singular cause of selective mutism, though it appears to be influenced by many potential factors (Nowakowski, et al, 2009). These potential causes include hereditary or genetic components, associated anxiety disorders, environmental stressors, temperament fears of being ignored, ridiculed, or harshly evaluated if they speak, or a direct result of inner anxiety and the subconscious defense of avoiding anxious feelings brought on by an expectation for speaking or communicating verbally (American Speech Language Hearing Association, n.d.) (Blum, 2007). It can also be caused by a mixture of the potential causes above, like familial links coupled with environmental factors, which could include reduced opportunities for social contact, observing anxious behaviors, or reinforcing avoidance behaviors. (American Speech Language Hearing Association, n.d.). Other causes could include trauma, a developmental milestone, social factors, or a major life event (which is where my selective mutism originated).

Signs and Symptoms

Selective mutism comes in many forms. Every person is affected differently, meaning there are multiple signs that can be spotted when diagnosing. The most common sign of selective mutism is the “consistent failure to speak in specific social situations in which there is

expectation for speaking" (American Speech Language Hearing Association, n.d.) but they speak freely at home and with people of their choosing. Other common signs of selective mutism are as follows:

- Become paralyzed with fear and/or shut down completely when unable to communicate
- Struggle to make eye contact
- Present as behaviorally inhibited
- Rely on gestures and nonverbal communication
- Speak through trusted adults, i.e., whisper to their parents or a friend and have them repeat what they said louder
- Are very clingy to parents or trusted individuals
- Hiding, running away, crying, or freezing when presented with uncomfortable or unwanted social interactions/situations
- Tantrums if asked to speak publicly
- Avoid doing everyday activities in public, like eating, using a public restroom, having pictures or videos taken of them, and initiating and participating in conversations
- Perceptive and sensitive
- Blushing, fidgeting, and other physical identifiers of anxiety
- Isolate or withdraw themselves from social situations when expected to interact and speak with others
- Freezing, becoming overly rigid or stiff, stands expressionless, or becomes tense and panicky

- "Heart beats fast, can't breathe easily, throat goes tight, can't even turn my head side to side comfortably" (American Speech Language Hearing Association, n.d.; Blum, 2013; Cundwell, 2006: Johnson, 2012; Kovac & Furr, 2019; Selective Mutism Association, 2022).

Diagnosis

As stated earlier, selective mutism is often misdiagnosed or goes undiagnosed. If it is diagnosed correctly, it is usually a late referral due to the "belief that children were just overly shy and would 'grow out of' quiet behavior" (Kovac & Furr, 2019). An official diagnosis is determined by the DSM-IV guidelines, which state that there needs to be a consistent failure to speak in social settings where people are expected to speak, the disturbance interferes with achievement in education and occupation, or with social communication, the failure to speak lasts for longer than a month and the failure to speak is not due to a lack of knowledge or comfort with the spoken language required, a communication disorder, autism spectrum disorder, schizophrenia, or another psychotic disorder (Selective Mutism Association).

Selective mutism is often diagnosed when a child enters school for the first time and it is usually noticed by the teacher. This is due to the fact that at home, there are no changes with the child's behavior because they continue to speak to their parents and other trusted adults as they would before. At school is where the signs will be prevalent because this is where the student is uncomfortable with speaking. According to (Kovac & Furr, 2019), "teachers may have the most accurate information about children's SM (selective mutism) symptoms" but they may also have a hard time identifying a child with selective mutism "because these students tend to blend very

well into the classroom; they are often not disruptive and appear studious, compliant, and intelligent" (Kovac & Furr, 2019)

Just like any other disorder, early identification and diagnosis is important. "The gap between symptom onset and time to referral can lead to greater resistance to intervention due to the pattern of negative reinforcement (or the withdrawal of request for verbal behavior) that evolves when a child does not respond" (Kovac & Furr, 2019).If misdiagnosed or undiagnosed, the anxiety will continue to grow, leading to "social isolation, poor school performance or drop out, self-medication with drugs and alcohol, inability to seek employment as an adult, and in extreme cases even suicide" (Blum, 2007).

Assessment

The assessment tools for selective mutism vary, but the three most common ones that are used are a selective mutism screening, a self-test or a questionnaire, or a comprehensive assessment.

"Screening for selective mutism is conducted whenever selective mutism is suspected" (American Speech Language Hearing Association, n.d.). If a parent or teacher has noticed signs that a child may have selective mutism, they will go through the screening process. This process starts with a hearing screening to determine if hearing loss is a possible contributing factor to the lack of speech. Once that is clear, parents/caregivers and teachers report what they notice about the child and use competency-based tools, like interviewing, to determine if the child has selective mutism (American Speech Language Hearing Association, n.d.).

People experiencing symptoms are often the ones who take the self-tests, but in this case, the parent or caregiver can answer the questions based on their observations of the child. Self-

tests are not used as an official diagnosing strategy, just as a form of assessment. A selective mutism self-test would include questions similar to the following: (Selective Mutism Foundation, n.d.)

- Does your child have an ongoing fear of social situations involving unfamiliar settings?
- Does your child have persistent and unreasonable fear of speaking in the classroom, to other kids or adults including school settings, restaurants, or a store?
- Does the anxiety interfere with your child's daily life?
- Does the child appear anxious when interacting with peers?
- When the child is expected to speak does he/she react by having a blank expression on his/her face?
- Does the child cling to parents or hide in a corner of the room when an outsider visits the home?
- Does the child worry excessively about speaking in public?
- Does the child worry excessively about being called upon by the teacher in class to verbally respond?
- Has the child suffered in classroom performance due to non-verbalization?
- Is the child reluctant to go to school or avoid age-appropriate social activities?
- Does the child experience headaches or stomachaches about attending school?
- Does the child speak at home in a normal voice but does not verbalize in public?
- Has the non-verbalization in school or public settings been for more than a month?

Questionnaires, which are similar to this self-test, are also used as a form of assessment for selective mutism. R. Lindsey Bergman, Ph.D., created a Selective Mutism Questionnaire that

is featured on the Oxford Clinical Psychology website. This questionnaire includes 23 questions that have been split into the categories “at school”, “home/family”, “in social situations (outside of school)” and “interference/distress”. Each question in the first 3 categories is answered on a rating scale, from 0-3, where 0= Never, 1=Seldom, 2= Often, and 3= Always. The lower the score, the more likely it is that the child has selective mutism. The questions in the category “Interference/Distress” are rated “Not at all”, “Slightly”, “Moderately”, and “Extremely. This section is not scored along with the first three.

Statements on this questionnaire include the following:

AT SCHOOL:

1. When appropriate, my child talks to most peers at school.
2. When appropriate, my child talks to selected peers (his/her friends) at school.
3. When my child is asked a question by his/her teacher, s/he answers.
4. When appropriate, my child asks his or her teacher questions.
5. When appropriate, my child speaks to most teachers or staff at school.
6. When appropriate, my child speaks in groups or in front of the class.

HOME/FAMILY

7. When appropriate, my child talks to family members living at home when other people are present.
8. When appropriate, my child talks to family members while in unfamiliar places.
9. When appropriate, my child talks to family members that don’t live with him/her (e.g., grandparent, cousin).
10. When appropriate, my child talks on the phone to his/her parents and siblings.

11. When appropriate, my child speaks with family friends who are well-known to him/her.
12. My child speaks to at least one babysitter.

IN SOCIAL SITUATIONS (OUTSIDE OF SCHOOL)

13. When appropriate, my child speaks with other children who s/he doesn't know.
14. When appropriate, my child speaks with family friends who s/he doesn't know.
15. When appropriate, my child speaks with his or her doctor and/or dentist.
16. When appropriate, my child speaks to store clerks and/or waiters.
17. When appropriate, my child talks when in clubs, teams, or organized activities outside of school.

Interference/Distress

18. How much does not talking interfere with school for your child?
19. How much does not talking interfere with family relationships?
20. How much does not talking interfere in social situations for your child?
21. Overall, how much does not talking interfere with life for your child?
22. Overall, how much does not talking bother your child?
23. Overall, how much does your child's not talking bother you?

(Bergman, 2012)

The last form of assessment is a comprehensive assessment, which is a "collaborative approach with an interdisciplinary team consisting of a pediatrician, psychologist or psychiatrist, speech language pathologist (SLP), teacher, school social worker or guidance counselor, and family/caregivers" (American Speech Language Hearing Association, n.d). Before this assessment begins, it may be helpful to have the parent/caregiver send a video of the child's

communicative behavior at home so it can be compared to their behavior in a clinical or school setting. The comprehensive assessment begins with a diagnostic interview with the parents and teachers without the child present. In this interview, the parents and teachers are first asked what the suspected problems are. They are also asked about environmental factors, symptom history, family history, speech and language development, educational history including academic reports, parent and teacher comments, previous testing and standardized testing, and the amount and location of verbal expression, including questions about who the child talks to, in what circumstances the child is most likely to talk, where and what setting(s) the child is able to speak, and how the child communicates, whether with gestures, writing, sounds, whispering, and short responses (American Speech Language Hearing Association, n.d.).

If the child in question is bilingual, there are additional questions that are important for diagnosis and assessment. These questions are as follows: “What language does the child speak now? To who?”, “How well does the child understand different languages spoken to him/her?” and “Does the child speak their first language successfully outside of the home? If so, where and with who?” (American Speech Language Hearing Association, n.d.).

Along with the interview, a speech and language evaluation is done. This includes language comprehension (standardized tests and informal observations), expressive language ability (a video of the child at home), non-verbal communication (pretend play, drawing), functional communication ability across multiple situations and settings, and oral-motor functioning (strength, coordination, and range of motion of lips, jaw, and tongue) (American Speech Language Hearing Association, n.d.).

Treatments

Once a child is diagnosed with selective mutism, treatment should be discussed immediately. The purpose of treatment is to decrease the anxiety that the child feels and increase verbal communication in a variety of settings, incorporating practices and reinforcements for speaking in subtle, nonthreatening ways (American Speech Language Hearing Association, n.d.). The treatments should include approaches that gradually desensitize the child and allow for decreased anxiety in social settings where speaking does not occur, and over time, there should be progression from nonverbal to verbal communication (Selective Mutism Association).

For a child to receive treatment, they need to receive a referral for intervention. A referral for intervention can be issued in multiple ways "Caregivers may go through their local school district by contacting Child Find or speaking to their school guidance counselor to request an evaluation", "Teachers [can] meet with the child study team (school psychologist, behavior specialists, speech language pathologists and guidance counselors) to discuss their concerns and develop an appropriate course of action", or "Parents can talk to their child's pediatrician and ideally obtain a referral to a provider with experience in treating selective mutism, most commonly a psychologist, speech and language pathologist (SLP), or behavior analysist" (Kovac & Furr, 2019).

Once this referral for intervention is issued and the first meeting is scheduled, there are various strategies that should be used to ensure that the child is comfortable. These strategies include minimizing eye contact, using phrases and terms that encourage the child to communicate, creating joint attention using activities that the child enjoys, thinking aloud by providing behavioral descriptions of what the child is doing rather than asking direct questions, continuing a conversation even if the child does not respond verbally, maintaining a calm demeanor and environment, and considering the seating arrangements during the meeting

(American Speech Language Hearing Association, n.d.). The tone of this first meeting will affect how successful the treatments are and the rate of progress that the child makes, so it is extremely important to use and remember these strategies to avoid triggering the child's anxiety.

There are a wide variety of treatment strategies for children with selective mutism, including behavior strategies (contingency management, positive reinforcement, shaping, and goal setting, stimulus fading, exposure-based practices, and systematic desensitization), augmentative and alternative communication (AAC), augmented self-modeling, DIR floor time, and ritual sound approaches.

Contingency management is a treatment that consists of "administering positive reinforcement for exhibiting appropriate approach behavior and meeting specific goals during each session or meeting, with gradually increasing difficulty of the goals" (Selective Mutism Foundation, n.d.). It combines shaping (reinforcement of progressive approximations of a skill, such as frequency or volume of verbal communications until student performs it accurately each time), goal setting, and positive reinforcement. Once a behavior is rewarded with positive reinforcement, it is more likely that this behavior will occur again in the future. The first step in contingency management is to "identify and operationally define the student's current level of performance and the goal level of performance on the target behavior" (Sanetti & Luiselli, 2009). The goals should focus on frequency, location, or volume, and represent a progression of skill development from the child's current level of performance to their goal level of performance. When the child reaches their goal, the positive reinforcement, or the reward, should be provided. When it comes to deciding what the rewards should be, parents and teachers need to collaborate. If there is no collaboration, the rewards may include items that the child does not like, therefore it would not be motivating. (Sanetti & Luiselli, 2009)

Stimulus fading is another behavior strategy that can be used as a treatment for selective mutism. Stimulus fading is the practice of gradually increasing exposure to fear evoking stimulus (American Speech Language Hearing Association, n.d.), which in the case of selective mutism, is gradually increasing the number of people present when the child is speaking (Kovac & Furr, 2019), specifically people that they do not normally talk to. In order to have a successful stimulus fading procedure, it is important to assess where and to whom the child talks to, and who they are motivated to talk to. Then it is beneficial to create a list of potential individuals that the child can work towards speaking to (Sanetti & Luiselli, 2009). Once determined, the exposure can begin. The first exposure is done with just a parent in a room with the door closed while there is a new person outside of the room (Kovac & Furr, 2019). This step is first because the child is in a room with someone, they are comfortable talking to and they are unaware that there is another person outside the door. The second exposure involves speaking to a parent in the room with the door open while a new, unfamiliar person is outside of the room. The third exposure involves speaking to a parent while the new person is on the opposite side of the room. The last exposure is done with the child speaking to the parent while the unfamiliar person sits next to the child (Kovac & Furr, 2019). Each step in the exposure process brings the unfamiliar a little closer each time, which allows the child to become used to having an unfamiliar person present when talking. This provides them with time to become comfortable with the person being present. Even though the child is not speaking directly to the unfamiliar person, this is progress because they are speaking around someone they do not know.

Exposure-based practices are a “collection of techniques that require a child to say words in gradually but increasing difficulty or anxiety provoking situations” (Kovac & Furr, 2019). This is similar to stimulus fading because they are both exposing the child to a stimulus that

scares them. The goals of exposure-based practices include replacing anxious feelings and behaviors with more relaxed feelings and increasing the child's feelings of independence by gradually improving their ability to speak in different situations and with different people (American Speech Language Hearing Association, n.d.). Systematic desensitization, similar to exposure-based practices, uses gradual exposure to anxiety provoking situations, but pairs it with the use of relaxation techniques (American Speech Language Hearing Association, n.d.).

Augmentative and alternative communication (AAC) is a treatment that includes "supplementing or replacing natural speech with aided symbols and/or unaided symbols" (American Speech Language Hearing Association, n.d.). This treatment plan should not be used long term and should be carefully monitored to ensure that it is facilitating interactions like it should be, and not replacing the verbal communication that is being worked towards.

Augmented self-modeling is a treatment that includes repeatedly watching video segments where the individual is engaging in positive social and verbal interactions in comfortable settings while they are in an uncomfortable setting. This method allows for the child to have a glimpse of what they look like communicating while they are currently present in a setting that makes them uncomfortable (Klein and Armstrong, 2013).

DIR Floortime focuses on development, individual differences and relationship-based strategies and focuses on the concepts of self-regulation, attention, engagement, intentional communication, and purposeful problem-solving communication. The goals of this treatment plan are based on evaluating the child's FEDC, or functional emotional developmental capacities. These include "moving from nonresponsive, to using gestures, to making sounds, and then to being verbal" (American Speech Language Hearing Association, n.d.). This treatment

incorporates sensorimotor activities, play-based activities, and anti-anxiety strategies from social workers or other behavioral health professionals.

The Ritual Sound Approach is a "cognitive and behaviorally based treatment" (American Speech Language Hearing Association, n.d.) that "first teaches sound production from the mechanical perspective; then, shaping occurs to reinforce oral movements with sounds that gradually progress to phonemes, syllables, and words" (Shipon-Blum, 2010).

The Social Pragmatic Approach emphasizes the participation in social engagement at levels varying in difficulty. This approach first looks at who the child communicates with, where the child communicates, the purpose of the communication and the child's ability to maintain conversation. As the child progresses through the treatment, the level of difficulty in social engagement increases. This approach is used to move the child "from acceptance of being a part of joint activities (such as games, art, social play), then using nonverbal communication (reaching, pointing, gesturing, yes/no, facial expressions) during joint activities, and through a hierarchy of production of sounds (i.e., non-speech sounds to speech sounds, and finally to using words) (American Speech Language Hearing Association, n.d.).

Selective Mutism in Schools

Effects on School

One of the criteria required for a selective mutism diagnosis is the interference with education or occupation achievement, or with social communication. Not everyone is affected academically, but selective mutism can affect a child's performance in school. Selective mutism can reduce a child's opportunities for social interactions with their peers, which in turn reduces their growth and development of social skills, making them seem unsociable (Crundwell, 2006).

As for academics, girls with selective mutism scored significantly lower on receptive vocabulary tests as compared to community controls, but there were no significant differences for boys. Students scored significantly lower than the community controls on math tests. They were still average or age-appropriate scores, but they were significantly lower than other students (Nowakowski, et al, 2009).

Disregarding test scores, it is a lot harder in general to assess what a student knows and what they don't because they don't speak. It is difficult for a teacher to tell if the child doesn't know or understand something because they don't raise their hands to provide answers, and they also don't raise their hands to ask questions. During tests that are done verbally, it is impossible to assess what a student knows because they may not answer verbally or read aloud (if reading is being assessed).

Sharing Concerns with Parents

If there are concerns noticed in the classroom, it is extremely important to notify parents of these observations. But it is also important to understand the correct way to make the parents aware. Before reporting to anyone, make sure to have a notebook or a document of observations that have been noticed in the classroom. Then before going to a parent, it is important to share observations with a school administrator, psychologist, or counselor (Selective Mutism Association). Once a school administrator, psychologist, or counselor is made aware of these observations, share them with the parents. It is extremely important that as a teacher, you are not diagnosing the child, just sharing what is being noticed in the classroom. Parents are going to need time to process the information that is being told to them, or they may want to provide the

child with more time to see if they become more verbal. Grant the parents' wishes and allow for more time if asked, but if the child is continuing to not make progress and the parents are not being open to intervention, the school psychologist or school staff should be notified so they can meet with the parent (Child Mind Institute, 2022).

Classroom Strategies

As a teacher, it is important to understand that students are not being rude, unfriendly, uncooperative, or defiant when they are not speaking, they just do not feel comfortable enough or feel too scared and anxious to speak. The children are not refusing to speak, they want to talk and participate, but their anxiety prevents them from doing so. Knowing this, it is important for teachers to understand and implement different strategies that can be used to help the child.

The most important thing that teachers need to understand is that forcing the child to speak will just make things worse for them. The child may respond with a temper tantrum or oppositional behavior (Selective Mutism Association, 2022). They may also retreat in any progress that was made up until that point in time, and they may end up back where they started. Pressure makes the situation worse, so teachers should not feel like they need to get the child to speak, it will come with time. They just need to provide different strategies and supports to make the child feel comfortable enough in the situation and with the people to speak.

Strategies that can be used in the classroom are as follows:

Allow the child to communicate in a nonverbal manner. This means that the child can use hand signals, classroom objects, 3x5 cards or signs with prewritten messages, word rings with prewritten words, or they can communicate by writing on the board or paper. This allows the

child to communicate and participate even if they are not completely comfortable with verbally communicating yet.

Create a warm and welcoming classroom that promotes lowered anxiety, building self-esteem, increased social comfort, progression of communication (Blum, 2007) and a lot of encouragement (Selective Mutism Association, 2022). In order for the child to speak, they need to be in an environment that feels safe, encouraging, and supportive (Crundwell, 2006).

Provide encouragement and positive attention to the child when they do speak. This should be done through labeled praise, descriptive phrases, and reflective phrases. But when this encouragement and positive attention is given, do not make it excessive, or too enthusiastic; this will create too much attention directed at the child and they will no longer want to speak to avoid that attention (Kovac & Furr, 2019).

Explain to the child that you understand that speaking in school can be scary but provide an open invitation to them that whenever they are ready, they can begin to speak (Kovac & Furr, 2019). This shows the child that you understand what they are feeling and that you accept that they are feeling this way. It gives them assurance that it is okay that they do not want to speak or that they need more time to warm up to the environment and the people before they are able to. Tell them that when they feel ready, you are there to help them and assist them in any way that would be helpful for them.

Observe the child and determine which settings, situations and which people are the most anxiety provoking to them (Kovac & Furr, 2019) and which situations, settings, and people do not provoke an anxiety response. Use these observations to come up with different strategies to help the child during those situations and with those people that do cause anxiety.

Talk to the child even though they may not answer back Show them that even though they are not speaking, you still want them to join in and be included in the activity or conversation (Johnson, 2012).

Treat the child just like any other student would be treated. Treating them differently would draw attention to them, which is one of the major things that causes their anxiety (Johnson, 2012).

Save the child a place near you or ask them to sit with you (Johnson, 2012). When on the rug or during whole class activities, sit close to the child so it is easier to hear them if they do speak (Kovac & Furr, 2019). During regular class time, it may be helpful to either put the child right near the teacher's desk, or far away from the teacher's desk. Being close may allow the child to speak to the teacher but being sat farther away may encourage the child to speak to their peers without knowing that the teacher is listening. Children with selective mutism do not like other people hearing them speak. So, if the child is comfortable with another peer in the classroom, it would be more beneficial for them to sit away from the teacher's desk so they know that they are not being listened to when they are speaking.

If another child says "________ doesn't talk/speak", correct them and say they do talk and that they are working on it (Selective Mutism Association, 2022).

Don't ask a lot of questions initially. Instead of asking questions, show or tell them things (Johnson 2012). But when questions are asked, it is important to begin with questions that can be answered nonverbally. Fixed choice questions are easier to answer than open-ended questions because they can answer with a simply yes or no, verbally, or nonverbally. Overtime, the child can be asked open-ended questions. When the child is asked any question, provide time for them to think about their answer. Wait at least 5 seconds for a response. Rephrase the question if

needed. Ask the question to other students first so the child has time to listen to others and think about their own answer (Kovac & Furr, 2019). Accept nonverbal answers but encourage verbal answers.

Show the child that they are amazing just the way they are and that even though they may not feel comfortable speaking, they are good at so many other things that do not involve speaking (Johnson, 2012). Show the child that this does not define them.

Help encourage friendships and social interactions. Engage and facilitate play. Give the child a partner or a buddy. Invite them to join in on large or small group activities (Kovac & Furr, 2019).

Avoid mind reading and encourage and reinforce speech rather than gestures (Selective Mutism Association, 2022). Remember that encouraging and reinforcing speech is different than pressuring the child to speak. The goal is not to force the child to speak, but to encourage them that when they are ready, they are free to talk.

Use videos as a way to communicate (Selective Mutism Association, 2022). Even though the child is still speaking in the video, they are not speaking in real time with other people around. They are speaking into a camera instead.

Stay positive and encouraging. It may seem frustrating that the child will not speak, but remember that they are not being defiant, manipulative, or controlling, they are afraid.

School-Based Interventions

Just like the treatments discussed above, there are also school-specific interventions that can be done to help the child overcome their selective mutism. "School-based classroom interventions require cooperation from parents, teachers, school administrators, and often school

support staff, such as school psychologists and social workers to develop and implement an effective treatment program" (Crundwell, 2006). This team (called a management team) works together to design and implement a plan, review the progress, resolve problems, and plan future intervention steps. There are 5 key steps for school-based interventions for selective mutism.

The first step is to turn to and involve all of the individuals that the child speaks to outside of school. Set up a conversation visit which is an in-school visit where an individual whom the child speaks to comes in and talks with the child. This allows the child to get used to speaking in the school environment.

The second step is to transfer the speech done in step one to a new activity, location, and/or individual. This means that the conversation can be moved closer to the classroom, with peers or another trusted individual, and to a different activity. This is a form of fading, where the speaking behavior in one location is gradually being transferred to another location in which it did not occur previously. This step can be repeated multiple times and "over time, the goal is to transfer speech from different activities to different locations as well as to different people" (Crundwell, 2006).

The third step is to implement an appropriate rewards system to assist in motivating the child to speak and help them overcome their fear. These rewards should be well planned and encouraging to the child. Examples of rewards include formal token programs, negotiable rewards contracts r naturally occurring reinforcers.

The fourth step is to focus on increasing in school conversational opportunities. Change the seating arrangements of the child to increase interactions. Allow for group activities or partners. Seat the child away from the teacher's desk to increase conversation with peers. Pair

the student with other children that they are comfortable with, whether they communicate verbally or nonverbally.

Step five is to monitor and evaluate the intervention and the progress that is being made. Note and track small interactions and observations to ensure that the intervention is successful. This may be difficult to track but it is important to track and observe as best as possible (Crundwell, 2006).

Along with this five step intervention program, the child can also have sets of goals that they can work towards reaching. The goals are arranged like a hierarchy, where they are harder to achieve as the intervention progresses.

The child will start with easier goals, such as making sounds with interventionists or teachers, answering forced choice questions from interventionist or teacher when alone with them, answering pen-ended questions from an adult when alone with them, answering questions from a friend when alone with them, asking questions to a trusted communication partner when provided with what to say, and talking to a trusted communication partner in a new place.

Once the easier goals are met, the child will them move on to medium goals, which consist of speaking to a trusted person in front of another person or in a small group, playing verbal games with few friends at recess, participating in small groups of students, and speaking to different adults around the school.

After the medium goals are complete, the child moved to the hard goals. These goals include answering when called on in class, giving a speech in class, greeting someone with hello or good morning, using social niceties like please and thank you, demonstrating self-advocacy skills, and seeking out an adult’s assistance when sick or injured (Selective Mutism Association, 2022).

These goals are not concrete goals that need to be met for every child that has selective mutism, they are just examples of what the goals can look like at each level.

Personal Experiences

My Experiences with Having Selective Mutism

When I was younger, I experienced selective mutism. But my selective mutism didn't start or wasn't noticed when I began school. I became selectively mute between the ages of 3 ½ and 4, when my younger brother was born. The birth of a sibling is a major life event, which is a potential cause of selective mutism. I had wanted a sister and not a brother, so when he was born, I stopped talking. I would only talk to a select few people in my family and a select few friends that I had. I spoke to my parents, my grandparents, one of my aunts, my best friend, and one of my cousins. Everyone else in my family tried to get me to talk or would just talk to me, and I wouldn't answer back. If I did reply, it was nonverbally, with gestures. When I started preschool, I still didn't speak. I would play with the other children in the class, and I still made friends, but I did not communicate verbally at all. I was completely silent in school until kindergarten or 1st grade, where I started to whisper answers to the teacher if I was called on. I still didn't speak to any of my peers except for one. The girl that I talked to had a disability that caused her to be delayed in her speech. She couldn't speak to me, so I spoke to her because I knew that she couldn't talk back. This was a major part of my selective mutism; I didn't want people to judge me for the things that I did say, so I just didn't say anything at all. But because this girl couldn't respond, I was comfortable talking to her. By second grade, I was speaking to some of my friends in my class, but I would only whisper, and I would only talk to them if no one else was around. After second grade, I moved to a new school and by this time, I was no longer

selectively mute. I was still more quiet, and didn't talk as much as others, but I no longer only spoke in certain situations with certain people. Instead, I was shy, slow to warm up to people but eventually I would open up and speak to them if I needed to.

The teachers that I had during the time that I had selective mutism never pressured me to speak. At first, they did not know what to do, because I didn't speak so they couldn't assess what I knew or where I was when I started school. But over time, they implemented some of the strategies discussed above, like giving me a partner, giving me jobs that did not involve speaking, and allowing me to stand up and whisper my answers in the teacher's ear. For assessments where I had to read aloud, I also had accommodations. For some assessments, I had the opportunity to take them at home, where I would be recorded reading the text and the recording would be given to the teacher to assess my reading level. These strategies were extremely helpful for me and they did not pressure me to speak, so I didn't regress back to silence.

Having selective mutism caused me to become extremely observant. I wasn't speaking, so I was watching and listening to everything else that was going on. So, since I wasn't speaking at school, right when I got in the car, I would explode. I would talk and talk and talk about everything I saw, everything people said, and anything else that happened that day. I would talk to my grandma the entire ride home, and then tell the stories to my mom all over again when I went in the house.

My Experiences with a Student Having Selective Mutism

When I was in high school, I was part of the Early Childhood Program. As a class during my junior year, we had to run the preschool lab that was located in the high school, creating, and

teaching lessons, creating the bulletin boards, creating a schedule, and teaching. The year that I was a junior, there was an extremely small class of only four students. One of our students would come into class and not speak to anyone. Not to any of the teachers or any of her peers. In the beginning of a school year, it is typical that children are shy, especially when walking into a classroom with new peers and 13 new teachers. But over the course of the first 2-3 months, she still would not speak to anyone. Not even a whisper. When she was asked a question, she would not answer, or if possible, she would answer nonverbally. Once 3 months had passed, the teacher of our class spoke to her parents to determine if she had any speech problems and to ask how she was at home. Her parents shared that she did not have any speech problems and that at home, she was very outgoing and talkative. This sounded very familiar to me, and we realized that she may have selective mutism.

So, during the next few months, I worked one-on-one with her. This is not something that is typically done, but there were 13 of us teachers and 4 students, so I was able to work one-on-one and build a strong relationship with her. Whenever the students did writing or math, and during free play, I made sure I was in the same area that she was in. I would talk to her and ask her forced choice questions so she could answer by nodding, shaking her head, or another form of nonverbal communication. After winter break, I continued to work one-on-one with her and continued asking questions and talking to her. After about a month of one-on-one work, she started answering me verbally, with quick, short, and quiet answers.

At this point in time, she would only speak to me. She wouldn't talk to any of the other teachers or any of her peers. She would whisper whatever she wanted to say in my ear and I would repeat it to the class. Though she would only verbally communicate with me, she still

participated and played with the other students. She enjoyed playing with her friends, playing dress-up or restaurant. She just didn't use words.

After some time of only speaking only to me and me sharing her answers with the class, she became more comfortable in the classroom. I believe that because she was still able to share her thoughts and communicate through me, her anxieties of people making fun of what she said were diminished. And by March, she was the most talkative child in the class.

Conclusion

Experiencing selective mutism allowed me to effectively help this girl overcome her struggles with it. I knew which strategies worked for me in school and what didn't. I knew what behaviors from others caused me to want to speak and which behaviors caused me to want to stay silent. I knew how to talk to her and how to make her comfortable enough in the class to be her true self. I knew that it would take time and patience for her to be ready to speak, and I knew that pressuring her would do nothing but harm. My experiences helped me help someone else, which is why I want to spread my knowledge of selective mutism and strategies for helping someone overcome this anxiety disorder.

Knowledge is key to understanding, and selective mutism is an anxiety disorder that a lot of people are not very knowledgeable about. It is mistaken and misdiagnosed for shyness or defiance when that is not the case at all. The purpose of this research was to clear up any of those misconceptions and explain that selective mutism is not just shyness or a child being defiant, but an actual anxiety disorder that children have that prevents them from speaking.

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