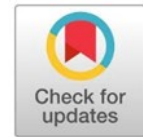


Quiet children and adolescents: Understanding and supporting youth with selective mutism

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ABSTRACT

Anxiety in children and adolescents can manifest itself in many ways. In the social context, some young people are so anxious that they find it impossible to express themselves. Selective Mutism then becomes an obstacle to their development. Families, schools, and clinics are often at a loss for information about this rare disorder. What are the keys to understanding and therapeutic levers?

The multiplicity of these young people's profiles will be illustrated through the clinical vignettes of Melody (3), Jeanne (8) and Sammy (15). Reliable and effective intervention strategies and tools are presented to support children in regaining their ability to speak.

The 'help strategies' used mainly combine CBT and systemic process-based interventions in individual and/or family formats. The progress made by children who have already benefited from these strategies reinforces our view that these approaches deserve schools' interest, support, and sound advice.



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1. Introduction

In children, anxiety can manifest itself in many forms such as excessive worrying, psycho-somatic symptoms (headaches, stomach aches, sleep disturbances), internalised and/or externalised problems (attention deficits, isolation, problematic behaviours). When it comes to social anxiety, some children can experience difficulty in expressing themselves, or in more severe cases, they can suffer from Selective Mutism (SM). Research has shown that only between 0.18% and 1.9% of children experience SM (Bergman et al., 2002; Sharkey & McNicholas, 2012). While this is a rare condition, it is a very serious issue, and it usually leads to high comorbidity, school refusal, isolation, and depression. This condition can be of major concern for the child's well-being, but parents, teachers and clinical workers may also experience great difficulty due to lack of information. The aim of this article is to provide clear insight on SM, illustrating differences in the presentation of this disorder dependent on the age and experience of young people through clinical cases and to draw attention to therapeutic facilitators, such as effective tools and strategies to support children regain their ability to speak in a social context.

Various descriptions and manifestations have been reported by clinical professionals when it comes to selective mutism disorder. Some children with this condition have been described as shy,

avoidant, and socially isolated while some have been observed to be oppositional, attention seeking or defiant. As children with SM often do not fit into a specific clinical profile, this condition has often been confused or misdiagnosed as developmental speech impairment, learning disorder or even autistic spectrum disorder (Fusar-Poli et al., 2022). It follows that SM, now classified as part of anxiety disorders (Association et al., 2015), is a rare condition that is not widely known. Its prevalence ranges between 0.03% and 1% in the general population (Association et al., 2015). According to recent research, the onset of SM usually occurs during childhood (Muris & Ollendick, 2015). Most commonly, this disorder initially manifests when children fail to speak in school (Kearney & Rede, 2021). It is characterised by the absence of speech in specific social contexts such as in school settings or social gatherings, as opposed to more familiar settings like home or with close family members where the speech remains intact (Muris & Ollendick, 2015). More specifically, certain social contexts such as unfamiliar extra-familial situations compromise these children's ability to verbally express themselves in contrast to other social situations where no difficulty of expression arises (Rosenbaum et al., 2016). The lack of the use of speech is not attributable to a lack of knowledge or lack of familiarity with language, nor any communication disorder such as fluency disorders or stutters, and is not exclusively linked to autistic spectrum disorders, schizophrenic disorders, or other psychotic disorders (Association et al., 2015). Up until the 1960s, previous terms to describe this disorder such as *Apahasia voluntaria* or *elective Mutism* wrongly suggested the silence of these children was voluntary, even to some extent defiant. In order to fit SM diagnosis criteria, the absence of speech has to last at least one month. However, most often, children can feel worried or anxious during times of change such as when starting school for the first time, which is considered normal and therefore should be considered before diagnosing it as SM. To a certain extent, some degrees of reluctance, taking the form of absence of communication, should be considered normal when a child is placed in new or unfamiliar situations (Muris et al., 2016).

Research has shown that SM is slightly more prevalent in girls, with a mean of two girls for one boy (Dummit et al., 1997). Children with SM can be sociable, humorous, curious, loud and talkative in a familiar setting. It is the contrast between their behaviour and attitudes at home with the outside world that determines whether or not they suffer from SM. Symptoms usually appear between two and five years old (Oerbeck et al., 2020). At first, signs can start insidiously and be observed in the first years of life when the child is in the presence of strangers, usually adults, to whom they refuse to speak, referred to as primary SM. In other cases, which we refer to as secondary SM (Catchpole et al., 2019), symptoms can appear as a reaction to a perceived stressful situation, usually when the child starts school. Suddenly the child stops expressing himself or herself in social situations which was not an issue before. In very rare cases, some children will also experience SM in their home (intra and extra-familial mutism).

Specialists suggest SM results from the complex interaction between diverse vulnerability factors such as psychological, linguistic, familial, cultural, and genetic factors. The constellation of vulnerability factors differs for every child therefore, it is important to adapt therapeutic plans to each child. SM can last an average of eight years. After which the main symptom (absence of speech) usually resolves itself normally or completely disappears (Remschmidt et al., 2001). However, studies have shown that children who have suffered from SM and have not had the necessary psychotherapeutic care and support continue to have communication issues up to adulthood. They are also more susceptible to difficulties in school and/or at work and present higher rates of psychiatric disorders (Remschmidt et al., 2001; Steinhäuser et al., 2006). Unfortunately, parents tend not to seek specific help when the first sign of SM appears due to the preconceived idea that the child is just timid and will eventually talk. Nevertheless, children who receive the proper support show significant improvement. Therefore, the work of psychologists, doctors, therapists and nurses is critical in the sensitisation of educational teams to SM in order to assure early guidance and orientation of families.

In general, psychologists make the diagnosis and orient parents. However, doctors, nurses, speech therapists, educational teams and parents are also at the frontlines of identifying SM. Therefore, the first step in supporting children is by spreading more common knowledge on what SM is to the general public. In France, the public organization *Ouvrir la voix* (in English, "Open the voice") has helped create materials and helpful resources on SM (Voix, 2018). Moreover, for therapeutic efficacy, it is also crucial to destigmatise children and their close ones.

- Children: by validating their feelings and by explaining to them that they are not doing it on purpose;
- Parents: by implicating them closely in the process and as active contributors to their child's progress;
- Teachers and school staff: by validating the difficulties of working with a child that does not express him/herself, by positively reinforcing what may have already been put in place with the child (supporting the child, giving the child space, respecting the child's timing, encouraging expression, etc.) and answering their legitimate concerns by giving them more information and helpful resources on this disorder. It is also very important to have the teacher on board with the therapeutic process and to explain the level of implication they may have;
- Medical and paramedical professionals: by recognising and validating the difficulties in establishing and adapting interventions for children that do not express themselves (Zebdi, 2018).

Defocused communication is a tool often suggested to the child's close environment as a means to give the child an opportunity to speak without the expectation of them doing so (Oerbeck et al., 2020; Schwenck et al., 2022). It is suggested to: (1) sit beside the child (not opposite the child) whilst participating in an activity the child enjoys in order to create joint attention; (2) speak "thinking out loud", giving alternatives instead of asking direct questions; (3) model openness, patience and kindness; (4) let the child respond in his/her own time or wait a minimum of five seconds before talking for him/her (do not put pressure on a response); (5) continue the dialogue even though the child does not respond verbally, be open to non-verbal responses; (6) give the child an overview of the coming activities of the day; (7) ask closed questions; (8) favour games and physical activities the child enjoys; (9) if a verbal answer is received, try to answer in a neutral way and by not praising the child excessively.

2. Clinical Cases

2.1. Melody, 3 years old, silence as a coping strategy

Melody, aged 3, is the oldest child of two. She lives with her two parents and her younger brother, aged 1. At home with her family, she is a curious and affectionate little girl. Her parents describe typical early childhood and normal development for all functional abilities. When her little brother was born, her parents mentioned she had some difficulty with frustration, which resolved itself on its own. Melody started pre-school at the beginning of the school year, which is the starting point of her difficulties. Melody did not cry at drop-off or resist going to school. However, the teacher expressed worry as she would isolate herself during the day; she would not play with other children if any adult school staff were nearby and would not answer the teacher when she was addressed. After that first month of pre-school, the situations in which Melody would turn quiet spread to outside of school. Whenever a neighbour or a stranger could be within hearing distance, she would stop speaking. The teacher suggested that the parents take Melody to be evaluated by a therapist.

During the first sessions, Melody was quiet; the SM and general symptoms evaluation was done by parent and teacher-rated measures (Achenbach & Edelbrock, 2011; Achenbach & Leslie A, n.d., 2013; Bergman et al., 2008, 2013; Oerbeck et al., 2020). The assessment revealed internalised symptoms of anxiety and SM in and outside school.

A Cognitive and Behavioral Therapy (CBT) treatment plan was put in place with the help of Melody's parents and teacher. However, because of Melody's young age, a behavioral approach was opted for. The first sessions were centered on psychoeducation to explain social anxiety and selective Mutism to the child and her family. This was also explained to her school teacher in a separate meeting. Then, defocused communication was taught to her parents and teacher in order to maximise communication in anxiety-inducing situations and to prevent any further isolation. This was crucial to help them understand Melody's feelings and behaviours, but also gave them tools to help her cope in these situations. Triggering situations were then listed in a hierarchical order for gradual exposures. Less triggering situations were targeted first (playing with mum next to another adult in school) in order to reduce the feelings of fear experienced by Melody before tackling more complex situations (looking the teacher in the eyes and answering questions). Each exposure situation was closely worked on with the help of her parents and teacher.

For the first exposures, the school and teacher's flexibility allowed for fast improvements as Melody's parents were able to be present on school premises. As progress was made, her parents spaced out their school visits. This helped Melody confront her anxiety but in a progressive manner, which had essential motivational effects. Relaxation methods were taught to her parents and her to help her cope with the stress she would feel in adverse situations; these were practiced every day in and outside the home. To reduce isolation, a "safe place" at school was determined in accordance with the teacher, where Melody could go when feeling overwhelmed and then encouraged to come back and interact with the other children. Photolanguage resources were also given to Melody and her teacher in order for her to be able to communicate her needs. Finally, a system of positive reinforcement was put in place at home to positively reinforce social behaviours (i.e., "smile at neighbour," "pay for the bread at the bakery," etc.) and maintain motivation on a daily basis outside of school premises.

After just eight sessions, thanks to the engagement of all the contributors (teacher, parents) and Melody's cooperative nature, she was able to speak to the teacher, speak in the streets with her parents close to strangers, speak to her parents during therapy sessions and talk with other children in school. Another five sessions allowed Melody to freely express herself to her teacher and be less avoidant of strangers.

2.2. Jeanne, 8 years old, silence and flexibility difficulties

Jeanne, aged 8, is the oldest of two siblings. She lives with her two parents and her younger brother, aged 3. When she is with her family, she is a smart and curious young girl. Her parents describe an early childhood with no extraordinary events and a typical development for all functional abilities (first words, first steps, cleanliness). After the first six months of her life, Jeanne's mother returned to work and left her in the care of a nanny. The nanny had a good relationship with Jeanne, and there were no separation issues. Everything went well on Jeanne's first day of kindergarten. Despite being reserved, she spoke with both the teachers and the other children. However, when she realised that she would be returning and became aware of the separation from her nanny, she cried excessively and manifested high levels of distress whenever she had to go to school. This lasted over a month. Over this time, she became apathetic and selectively mute during the day.

The child regularly demanded to return to her nanny and was disinterested in school-related activities, which further isolated her from the other children, reducing her social interactions. During the following years of kindergarten, Jeanne continued not to speak, preferring to communicate nonverbally with the teachers until the last year of kindergarten where she would speak with her teacher only when they were alone. Her parents explained that Jeanne liked her teacher and that the teacher was able to be on Jeanne's "good side". The following year, Jeanne started her preparatory year in a new school, and her Mutism continued, preventing her from verbally communicating in both curricular and extra-curricular settings.

After two years of Jeanne experiencing these difficulties, her parents asked her to help and to be evaluated for her school work by her teachers. During the consultation, her father reported that he too had been mute during school and had always experienced difficulties during his schooling regarding public speaking, up until university. On her mother's side, the whole family displayed great shyness and are qualified as "silent". Her parents wished to help their daughter gain confidence and to be able to thrive and develop harmonious relationships outside of her own family.

Jeanne presented as a shy and reserved little girl who avoided interactions of any kind, hiding slightly behind her parents. She discreetly observed her surroundings and people when she did not feel watched. She was still interested in what happened around her, drawing when invited to and smiling when she heard the psychologist say she was not obliged to speak. She enjoys playing cards and other games that do not require her to speak. Following a preliminary evaluation of Jeanne's difficulties using questionnaires, the Screen for child anxiety related emotional disorders (SCARED) (Behrens et al., 2019), Child Behaviour Check List (CBCL) and Teacher Report Form (TRF) (Achenbach & Edelbrock, 2011; Achenbach & Leslie A, n.d., 2013), Selective Mutism Questionnaire (SMQ) (Bergman et al., 2008) and the Schedule for affective disorders and schizophrenia for school-age children-present and lifetime version (K-SADS-PL) interviews (Kaufman et al., 1997), the outcome points to social anxiety and a comorbidity of selective Mutism. The family was proposed cognitive behavioral therapy with sessions of parental guidance and systemic family sessions since it

appeared that the nonmedicated treatment offering the best possible outcome was this specific combination.

Cognitive behavioral therapy (CBT) began with psychoeducation for Jeanne and her parents on what selective mutism is (Muris & Ollendick, 2021; Vogel et al., 2019) and social anxiety, explaining what fear is and its utility as an alarm bell. Jeanne and her parents were then asked to make a list of every fearful situation to select and organise situations that can best be targeted for gradual exposure and become habituated with confronting anxiety-inducing situations to reduce the feelings of fear experienced by Jeanne.

The family was explained that Jeanne's silence is associated with fear that she experiences during aversive situations. Parallel to this, the team revealed to Jeanne's parents all of the fearful situations in order to conduct a functional analysis to identify factors that contribute to the maintenance of these difficulties. The parents realised that they had diverging beliefs when it came to managing these situations - the mother tends to try to encourage Jeanne to confront her fear, while her father prefers to drop the situation in order not to put his daughter in a difficult position. Quickly, we realised that due to the family's habits and her experiences with her parents, Jeanne lacks flexibility and requires more time to become habituated to a new situation than other children her age.

After several months of therapy, Jeanne started progressing and building more autonomy. She increased her interactions with others, especially at school, where she signed up to recite her lessons with the school teacher and sent voice messages and videos to her therapist. When the therapy sessions focused on increasing and diversifying her exposures, we noticed that Jeanne was much more successful in adapting to new contexts. Changing contexts allowed her to adopt new behaviors that she has been practicing, as she made new friends in a new setting and whispered in the ear of a supervisor. However, her progress was less visible in more familiar environments, as if the lack of flexibility held her back from adjusting her behavior in environments where she had become accustomed to not speaking. Similarly, we tested changing the consultation office, and Jeanne whispered in the ear of her father in order to speak to him in front of the psychotherapist. The procedural approach in psychotherapy appears to be useful to use with Jeanne to work on her cognitive flexibility and help her speak in all situations.

2.3. Sammy, 15 years old, when silence hides trauma

Sammy, aged 15, is the eldest of three siblings. He lives with his two parents and his younger twin sisters, aged 10. He comes for a consultation due to school refusal due to anxiety and selective Mutism. He is a happy young man, described as kind and loving by his parents. The family is originally from the Middle East, where Sammy was born. After his birth, Sammy's father was expatriated to France to find work, and his mother took charge of the rest of the family while they stayed behind, leaving Sammy's grandmother to help raise him and his siblings. Sammy's mother explains that he preferred to be in his grandmother's arms and that, seeing this strong attachment, she preferred to leave him with his grandmother.

When Sammy was three, he and his mother moved to France to definitely rejoin his father. He continued to develop properly but presented as shy and reserved, even with his own parents. He quickly integrated kindergarten, where he enjoyed being, and made a few friends. His schooling was going well, but his teachers signaled a lack of vocabulary and a slight speech delay and suggested that bilingualism may be the reason for this. They suggested that his family stop speaking Arabic at home so that Sammy's French may improve. The mother now exclusively speaks French; however, as his father does not speak French very well, he continues to speak to Sammy and his daughters in Arabic. The mother explains that his father is very reserved and that he and Sammy are very similar in this regard. The rest of his schooling went on without any particular issues up until high school. There, he finds himself in a class with a very demanding teacher, which triggers Sammy's anxiety. Going to class is met with growing apprehension, at which point he starts to manifest stomach aches in order not to have to go to class. With great fear, he continues to go to class, until the teacher eventually decides to do an oral exam. Once Sammy's turn arrives, he is incapable of answering the teacher. He stays mute and is sent out of class. He becomes incapable of going to high school. He has panic attacks before getting into the car in the morning or cannot get out of the car once in front of school.

Following this episode, the parents requested to change his school and the request was accepted. Sammy then starts cognitive behavioral therapy when starting at this new school, which is smaller and

has fewer students. A progressive integration program is put in place for him by the school. He is now attending for one hour a day, four times a week. His absence of speech persists with other adults and schoolmates.

Sammy's therapeutic sessions were initially centered on the traumatic experience involving his strict teacher for which he proposed Eye Movement Desensitization and Reprocessing (EMDR) therapy, targeting the memory that triggers strong negative emotions. Following these sessions, Sammy appears more peaceful and has an improved quality of sleep; he no longer presents with nightmares or flashbacks. His parents describe him as gaining a newfound interest in playing with his siblings and starting to get back in contact with his old close friends.

We then suggest targeting symptoms of performance anxiety which are contributing to his refusal of school, suggesting gradual exposure therapy to fearful situations from easiest (i.e., going to an appointment with the school psychologist and playing a game with her in her office) to more challenging (go to class for a morning). Meanwhile, Sammy practices speaking in front of people outside his family, including his neighbor while he is out to buy bread or picking up his sisters from their after-school activities. To introduce communication within the school, we suggest that Sammy write down his questions for the psychologist or the teachers to read; in the following step, we suggested he record himself asking questions to be played and listened to in an individual setting. The procedure takes place over several months, and Sammy is finally able to attend school partially at the end of his first year of therapy.

The absence of speech for Sammy was a sign of freeze he experienced when confronted with what he perceived as a threat, but also a symptom of his school-related anxiety. After a year and a half of CBT, Sammy was able to start to discuss his family history and his attachment to his parents and grandmother. Family therapy sessions allowed us to discuss the parenting challenges experienced during Sammy's first years of life. A few years after the end of his treatment, Sammy obtained his high school diploma and began pursuing studies in communications. He started theatre and now regularly challenges himself during his performances.

3. Discussion

Literature suggests that Cognitive and Behavioral Therapy (CBT) is the most effective in treating SM (Cornacchio et al., 2019; Oerbeck et al., 2018) combined with a systems intervention approach (He & Antshel, 2017). Resources are available in French, such as the Progressive Introduction of Speech in School program established by Ouvrir la voix (Voix, 2018). Other programs are available in English such as Integrated Behavioral Therapy (Bergman et al., 2013) or Taming Sneaky Fears (Benoit & Monga, 2018; Monga & Benoit, 2018), which is manualised and developed specifically for children aged between four and seven years old. Group programs have also been developed for children and adolescents such as Take Action (Waters et al., 2008) and Fun Friends (Barrett et al., 2015), ten-session manualised programs for children from four to 18 years old. In theory, authors suggest that children with SM's nonverbal behaviors should be considered an emotion regulation strategy (Cole & Jacobs, 2018). By staying silent, they reduce the intensity of anxiety or other negative emotions in difficult or stressful situations. Speech avoidance is a maintaining factor of SM just as avoidance suppresses unpleasant symptoms of anxiety, which long-term reinforces avoidance mechanisms (Hofmann & Hay, 2018). In supporting these children, parents and professionals should place emphasis on and positively reinforce the development of coping skills that deal with the underlying anxiety (Biggs et al., 2019). When treating SM, the first steps are to make sure that the child's difficulty is, in fact, relevant to SM diagnosis, to estimate the intensity of the Mutism and to assess the triggering situations for the child. Therefore, standardised assessment measures have been developed such as the Selective Mutism Questionnaire (Rodrigues Pereira et al., 2022) and the Speech at School Questionnaire (Oerbeck et al., 2020) to evaluate symptoms of SM. They were conceived with the intention of giving a quantitative measure of the intensity of symptoms and their impact on the child's well-being. They allow parents and teachers to describe in detail the verbal abilities of the child in different situations if they observe differences during the day, or in specific activities, or when the child is in the presence of other people (Bergman et al., 2002; Muris & Ollendick, 2021). Following these measures and with the help of child-friendly resources, psychoeducation is a crucial step in explaining to the child his difficulties and the mechanisms of SM. CBT concepts should be

explained to children and their parents with active demonstrations and graphic illustrations. Once the concepts have been explained, therapeutic engagement should be obtained by the child, his parents, school staff (teacher, headmaster, school doctor or nurse, etc.) and medical or paramedical professionals (psychotherapist, psychologists) and associates (Association Ouvrir la Voix, Selective Mutism Association, Selective Mutism Information and Research Association, etc.). Most existing CBT programs dealing with SM follow these steps in the active phase of treatment.

- Paying attention and bringing consciousness to anxiety and its physical manifestations;
- Cognitive restructuring or anxious thought, for instance, the thought of our voice sounding strange to others (work on interior monologue by introducing alternative thoughts) and using calming relaxation techniques and coping skills to help cope with social anxiety symptoms;
- Participants also learn through systematic desensitization or progressive exposure therapy for children how to overcome their fears of speaking and socializing. Educational professionals and parents should be informed of these steps;
- The implementation of graduated exposures, either in or outside the school, with the help of a verbal intermediary (determined person with whom the child feels safest) throughout the exposure. The goal is to progressively increase verbal speech situations within the child's tolerance window, respecting his timing until he can speak in all contexts in and outside of school. Positive reinforcements of the child's achievements and progress are pivotal throughout this process;
- Problem-solving strategies and assertiveness exercises to help deal with intimidating situations;
- Gradually spacing out sessions and planning relapse-preventing sessions to help guide the child and his family if symptoms resurface.

4. Conclusion

The core symptom of selective Mutism, the absence of speech, appears to be relatively uniform, but it is not pathognomic of a specific psychopathological structure: it is present in many clinical tables. Selective Mutism is an anxious disorder that stems from a combination of different genetic and environmental factors. It can sometimes be seen as isolation and this expression of anxiety should not be underestimated. It can also be a symptomatic expression of social anxiety combined with a process of cognitive (in)flexibility or even an expression of trauma underlying an attachment disorder. Whatever the cause, this expression of discomfort through the absence of speech should lead clinicians and pedagogues to try and understand the meaning behind these manifestations in each child, regardless of whether the child remains mute or not.

Even if SM is still considered rare in its numbers, its acknowledgement is growing and seems to be more frequently noted within the medical, academic and psychosocial fields. Nowadays, children experiencing SM and their families can access specialised treatments and resources, implicating schools, teachers and outside clinical professionals. Moreover, it is highly recommended that clinical professionals dealing with children who have SM stay vigilant to the multiple forms this disorder can manifest itself. For future research, focus should be put on developing international programs for treating SM and establishing specific training for professionals in order to broaden accessibility to treatment.

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Declarations

Author contribution : Rafika Zebdi was responsible for the entire research project. She led the writing of the manuscript, data collection, data analysis, and the final revision. Jessica Monsillion was in charge of the first draft,

collecting and analyzing the data. All of the authors approved the final manuscript.

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