UNIVERSITY OF Southampton

Doctoral Programme in Educational Psychology

How can we use an understanding of individual differences to support children with selective mutism?

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Selective mutism (SM) is the term used to describe a condition most prevalent within early childhood (Wong, 2010) involving a consistent absence of speech in specific situations, such as at school, whilst speech remains normal in other situations (Khan & Renk, 2018). For a child to be diagnosed with SM, their lack of speech must have been present for more than one month after their first month at school, not be a result of unfamiliarity with the language or a language disorder, and not be better explained by an autism diagnosis (Muris & Ollendick, 2021). Selective mutism was previously termed 'elective mutism' in the 'other disorders of infancy and childhood' section of the Diagnostic and Statistical Manual of Mental Disorders (3rd ed.; DSM–III; American Psychiatric Association [APA], 1980) before being relabelled 'selective mutism' in the DSM-IV (APA, 1994). The condition was then reclassified as an anxiety disorder in the DSM-5 (APA, 2013). These changes reflect our evolving understanding of the nature of SM, previously believed to be an active choice not to speak as a result of oppositionality, whilst now it is understood to have an anxiety pathology (Sharp et al., 2007). Due to its rarity, reported prevalence rates of SM vary and have been challenging to establish but are generally reported to be between .46% and .76% of children (Viana et al., 2009). However, it is believed that SM may be underreported due to a lack of understanding of the condition and difficulty with identification before a child starts school (Mulligan & Shipon-Blum, 2015). Despite the reported infrequency of the condition, it is one that has a significant academic and social impact (Hua & Major, 2016) and affects the mental health and wellbeing of children and young people (Lawrence, 2017). Furthermore, SM can have a substantial and detrimental long-term impact if not addressed effectively (Remschmidt et al., 2001). Unfortunately, there is not an established method of supporting children with SM that has been identified as being successful in most cases (Krysanski, 2003). SM research has been gaining traction over the past decade and rather than being viewed as solely an anxiety disorder, there is now increasing evidence that SM is a heterogenous condition, which could explain the challenges that exist with identifying an appropriate and effective method of support. This essay aims to contribute to the growing body of literature seeking to better understand how to effectively support children with SM. Findings related to the individual differences associated with SM and the environmental factors that maintain non-speaking behaviour will be discussed, with the aim of exploring how these factors can help increase our understanding of how to support children with SM using a holistic approach.

As previously mentioned, the current classification of SM in the DSM-5 identifies the condition as having an anxiety pathology and there is a substantial amount of evidence providing support for this classification. Much of this evidence examines the similarities between SM and other anxiety disorders, arguing that the overlap is indicative of SM being an anxiety disorder. A recent meta-analysis carried out by Driessen et al., (2020), found that anxiety disorders were present in 80% of children with SM, with social anxiety disorder being the most common comorbid anxiety disorder. Many of the studies included in this analysis use parent-report measures to assess anxiety (Bergman et al., 2002; Cohan et al., 2008; Kristensen, 2000), namely the Social Anxiety Scale for Children (La

Greca, 1999). Although this measure has good internal consistency, a reliance on parent-report measures is not ideal given that agreement on anxiety symptoms does not always exist between parents and children (Barbosa et al., 2002). Moreover, whilst the aforementioned meta-analysis indicated that the majority of children with SM involved in the studies had anxiety symptoms, this outcome was not universal and subsequently not all researchers are in agreement that SM is exclusively anxiety-based. An arguably substantial proportion of children were found to not have an anxiety disorder, which could indicate that SM is misunderstood for a number of children. Whilst this is an important factor to consider, it is also important to note that the presence of an anxiety disorder, or lack of, is not necessarily indicative that SM is caused, or not caused, by anxiety. With this in mind, studies that evidence the anxiety classification of SM have also explored the underlying fears specific to SM, using self-report measures. In an online survey completed by 65 children with SM, 18 with social anxiety disorder, and 51 with no condition, Vogel et al., (2019) found that children with social anxiety disorder and SM expressed significantly more social fears but children with SM also reported specific speech-related fears. A similar study revealed that when watching videos of specific scenarios, children with SM found speech-demanding scenarios significantly more anxiety-inducing than children with social anxiety and a control group (Schwenck et al., 2021). This indicates that children with SM may have an anxiety pattern specifically related to speaking. It seems clear that anxiety plays a role in SM, however more research using clinical, standardised, and physiological measures would be useful for clarifying the nature of the anxiety presented in SM.

Despite having a thorough understanding of childhood anxiety disorders and the growing body of literature aimed at increasing our understanding of SM more specifically, we still do not fully understand the nuanced differences associated with the condition (Skedgell et al., 2017). Whilst the interaction between anxiety and SM is somewhat established, it is also important to consider the increasing evidence suggesting that it is uncommon for children with SM to experience exclusively anxiety and recognise that the scope of the condition is likely to be broader. Research has begun to indicate that there may also be a number of cognitive, behavioural and emotional factors associated with SM. One example of this lies within the domain of speech and language. Significant language disorders are an exclusion criterion for SM in the DSM-5 (APA, 2013), however, research indicates that a subset of children diagnosed with SM have poorer language skills than those without SM. Manassis et al., (2007) used standardised, non-verbal measures to assess the speech and language skills of children aged 6 – 10, 44 of which had SM, 28 had social anxiety disorder, and 19 had no condition. The results revealed that children with SM had significantly lower receptive language scores than the other groups, with a large effect size. These results replicated a previous study by the authors (Manassis et al., 2003), indicating that whilst scores remained within the non-clinical range for most participants, some children with SM may still experience some level of language difficulty that may contribute to apprehension around speaking. Kristensen, (2000) also found poorer expressive language, in addition to receptive language, in almost a third of a sample of 58 children aged 2-14 with SM, compared to a matched control group, using non-verbal standardised assessments, parent interviews, and home audio recordings. Additional studies have also found that children with SM produce shorter narratives than those with social anxiety disorder (McInnes et al., 2004). Assessing the language skills of children with SM can be challenging given their avoidance of speaking outside of home, so parent-report measures are often used (e.g. Cohan et al., 2008). However parents often overestimate their child's proficiency with language (Stein et al., 2001) and it is therefore positive that the aforementioned studies did not rely exclusively on parent-report measures, with the majority employing standardised language assessments. The broad age ranges included in the studies also potentially increase generalisability. However, the evidence base for the presence of language difficulties is still limited, nevertheless it does suggest that language differences may be present for some children with SM, even when a clinically identified language delay has been ruled out.

Whilst our understanding of the aetiology of SM has moved away from the perception that SM is an expression of oppositionality, to one of avoidance, there is still debate as to whether some children with SM also display oppositional behaviours alongside anxiety. Given the close link between oppositionality and anxiety (Fraire & Ollendick, 2013), it is not entirely unexpected that some children with SM may display behaviours that could be interpreted as oppositional. When compared with a control group, Cunningham et al., (2004) found that children with SM were rated significantly higher on the oppositional defiant disorder scale of the Revised Ontario Child Health Study (OCHS-R) scales (Boyle et al., 1993). However, in comparison to teachers, parents rated their child's behaviour as more verbally oppositional, suggesting a potential pattern of verbal oppositional behaviour at home compared to a more inhibited presentation at school. Whilst this finding supports earlier parent- and teacher-report studies (Krohn et al., 1992; Yeganeh et al., 2003), it is also disputed by several studies finding no significant differences between children with SM and comparison groups (Cohan et al., 2008; Cunningham et al., 2006; Vecchio & Kearney, 2005). The use of parent- and teacher-report measures in these studies could have led to misclassification of avoidance behaviours as being oppositional and could be the cause of the discrepancy in findings. To explore this relationship further, Diliberto & Kearney (2016) conducted an exploratory factor analysis on scores on the Child Behaviour Checklist, a parent-report measure with very good internal consistency (Achenbach & Rescorla, 2001). They identified a number of children with SM that presented with behaviours that could typically be seen as oppositional such as, 'argues a lot', 'temper tantrums' and 'stubbornness', whilst others presented mainly with more typical anxiety-related behaviours. Whilst the authors suggest this may be indicative of an oppositional profile in a subset of children with SM, it could simply suggest that children with SM use different approaches to avoid anxiety inducing situations, and identification of these specific behaviours could be useful for individualising support.

Another individual difference associated with SM in the literature relates to sensory needs. Some theorists suggest that SM is the result of high sensitivity (Johnson & Wintgens, 2017; Jones, 2011), also termed 'sensory processing sensitivity'. This refers to a personality trait characterised by a 'greater depth of information processing, increased emotional reactivity and empathy, greater awareness of environmental subtleties, and ease of overstimulation' (Aron et al., 2012). Recent research (Melfsen et al., 2021) explored this concept in 28 children, aged 7-14, with and without SM, using the 'Highly Sensitive Person Scale' (Aron, 2012), a parent-report scale with good reliability. Participants with SM had significantly higher scores than the control group and Melfsen et al., concluded that for children with SM, sensory processing sensitivity may trigger a freeze response when they feel unsafe in stressful situations. Despite the small sample, this research presents novel findings that link with research exploring emotional dysregulation and temperament in SM. Proponents of the sensory processing sensitivity theory argue that SM occurs when a child does not have the strategies to cope with the stressors in the environment. In line with this, research shows that children with SM have an inhibited temperament, meaning that new experiences elicit disproportionate levels of fear for which they need strategies to be able to cope with (Coll et al., 1984; Ford et al., 1998; Kristensen & Torgersen, 2002). Moreover, it has been suggested that children with SM have poor emotional regulation skills (Bronson, 2000), which consequently all leads to an adaptive response of mutism when they struggle to regulate their anxiety. Whilst again, more research is needed to clarify this relationship, the current evidence suggests there may be a need to consider temperament and regulatory strategies when supporting children with SM.

Whilst a number of individual differences have been found to be associated with SM, and it is important to recognise these differences, maintenance of SM symptoms should not be viewed as exclusively pathological. SM is an adaptive approach to the interaction between a child and their environment so environmental factors that maintain SM must also be considered. From a behavioural psychology perspective, which posits that consequences

determine whether a specific behaviour is reinforced and thus repeated (Woolfolk, 2016), a child's environment can be seen to reinforce their mutism (Anstendig, 1998). Parents can play a critical role in the maintenance of SM. Parenting style, and more specifically parental sensitivity, the level to which a parent adapts their behaviour to meet their child's needs (Park et al., 1997), can act to reinforce non-speaking behaviour. Insensitivity to a child's level of anxiety, resulting in too much pressure being placed on a child to speak when they are feeling anxious, can lead a child to associate speaking with heightened anxiety, thus increasing avoidance (Carpenter et al., 2014). Conversely, overly sensitive parents continually 'rescuing' the child from situations in which they are avoiding speaking, or allowing them to always respond non-verbally, can also unintentionally reinforce avoidance behaviours (Yeganeh et al., 2006). It is important that parents adapt their expectations to meet the needs of the child by continuing to facilitate opportunities for a child to speak and giving them time to verbally respond without expecting too little or too much (Carpenter et al., 2014). Given that school is the most common environment in which children with SM do not speak (Bergman et al., 2002), this balance also needs to be struck in the school environment to ensure that peers and teachers are not reinforcing non-speaking behaviour, an issue identified in numerous case studies (Khan & Renk, 2018; Reuther et al., 2011).

Parental anxiety has also been shown to impact upon the maintenance of SM symptoms. There is a higher prevalence of SM in children whose parents have a history of social phobia (Manassis et al., 2003) and other anxiety disorders (Alyanak et al., 2013). This suggests the potential for a genetic predisposition to anxiety, a link that genetic research suggests is a distinct possibility (Hettema et al., 2001). This could also suggest that SM may be a behavioural response learned through modelling, a process of imitating behaviours observed in others (Bandura, 1977). Parents may unknowingly reinforce their child's avoidance behaviour through modelling maladaptive behaviours, such as avoiding social situations themselves (Wong, 2010), or through an inability to model strategies used to address anxiety (Cunningham et al., 2004). It is important to note more generally, that if parents or school staff do not have knowledge of anxiety management strategies due to limited psychoeducation, it is understandable that they may not be able to support a child to manage their anxiety (Manassis et al., 2003).

There are a number of factors that need to be taken into account when considering how we can use an understanding of individual differences to support children with SM. Firstly, the evidence for SM being a heterogeneous condition highlights the need for practitioners to take a holistic approach to support. Several researchers have begun to outline 'profiles' which could be used to identify appropriate support mechanisms for children. For example Diliberto & Kearney, (2016) suggest children with SM may fit profiles of anxious, anxious-mildly oppositional, or anxious-communication delayed. Whilst effectively identifying the needs of children with SM is crucial, a system of profiles should be considered cautiously, as it may undermine the heterogenic nature of SM and encourage a reductionist perspective. Furthermore, it may lead to a reduced focus on the influence of the interaction between a child and their environment. Instead, a differential and multifactorial approach to exploring the cognitive, behavioural, affective, and environmental challenges that may be present for these children is warranted. Having a greater awareness of the individual differences that may be present for a child with SM can facilitate this thorough exploration of needs through consultation and home visits and help identify the possible areas for which further investigation is required in turn, facilitating a multimodal plan of support.

Currently there is not enough evidence provided by the available literature to meet the standard for evidence-based treatments, according to the APA's guidelines (Goodheart et al., 2006), therefore further investigation with larger samples and the use of randomised control trials, considered to be the benchmark for assessing interventions (Baron, 2004), is warranted. Nevertheless, the evidence base for effective methods of support is growing. A recent meta-analysis (Steains et al., 2021), examining the effectiveness of psychological interventions on SM, identified five randomised control trials that were of high enough quality for inclusion.

The analysis revealed that behaviour and systems-level interventions were more effective than no treatment at all on speaking and anxiety outcomes for children with SM. This suggests that behavioural interventions, aiming to address mutism as an adaptive strategy, that involve methods such as cognitive behavioural therapy, exposure therapy, contingency management and shaping, alongside systems-level interventions that provide psychoeducation and skills training for parents and school staff, could be effective approaches for addressing the anxiety and environmental factors influencing SM. Previous reviews reported similar findings (Cohan et al., 2006; Zakszeski & DuPaul, 2017) but are limited by the prevalence of single-case designs and lack of experimental control. Whilst the meta-analysis conducted by Steains et al., (2021) addresses these concerns, there were a limited number of studies, most of which still had small sample sizes. Furthermore, there is no indication of the long-term outcomes for the children involved in these studies. This highlights the significant need for more robust research into the effectiveness of psychological treatment approaches for supporting SM.

Whilst it is likely that psychological interventions are a good step towards addressing anxiety in children with SM and the environmental factors that may be reinforcing non-speaking behaviour, this may not be sufficient to fully address their needs and may suggest why an established treatment approach has not been identified. As this essay has outlined, there are several co-existing needs that may be present for children with SM and being aware of these facilitates an increasingly individualised approach to support. For example, the potential for children with SM to have coexisting speech and language difficulties suggests a need for interventions to also address these difficulties for some children. Some researchers have called for speech and language to be assessed in children identified as having SM, as well as the involvement of speech and language therapists, where language needs are present (Manassis et al., 2007; McInnes et al., 2004). In addition, the use of speech and language support approaches that can be used universally may also be beneficial. For example whole class approaches such as play-based teaching, whole-class language teaching through storytelling, and input from speech and language therapists in lesson plans, have been shown to be effective for improving language outcomes at school (Dobinson & Dockrell, 2021). Shared story stelling has also been shown to be effective for promoting language outcomes in a home environment (van der Pluijm et al., 2019). There are case studies involving the input of speech and language therapists that suggest their input may play an important role in the support of SM (e.g. Langdon & Starr, 2019), however it is important to note that the impact of language remediation has not yet been assessed in children with SM.

The potential for some children's adaptive strategies to present as oppositional also necessitates the need for an individualised approach to support. It has been suggested that children that present with more typically oppositional behaviours do not respond as well to cognitive behavioural therapy as those with more predominantly anxious behaviours, and an emphasis on skills training specific to oppositional behaviours, in addition to cognitive behavioural therapy and psychoeducation, may play a particularly important role for these children (Bergman & Keller, 2007, as cited in Cohan et al., 2008). Case studies also indicate that the implementation of reward systems alongside psychoeducation can be a particularly effective strategy for supporting children with SM presenting with oppositional behaviours (Ale et al., 2013).

Whilst the relationship between high sensitivity, emotional regulation, and SM requires substantially more clarification, it is also worth considering that psychological interventions may need to be individualised to address these needs. Given that cognitive behavioural interventions typically focus on the reduction of anxiety, this may not be sufficient for children that also experience high emotionality to new stimuli and difficulty regulating their emotions. The inclusion of strategies for self-regulation, environmental changes to make children feel safe within the school, and parent education related to self-regulation and temperament, may also be a crucial aspect of support for some children (Johnson & Wintgens, 2017; Melfsen et al., 2021). Some researchers also argue that an

assessment of emotionality is necessary (Kristensen & Torgersen, 2002).

As has been discussed, the need to factor individual differences and environmental reinforcement into a holistic plan of support is crucial, but the need for early intervention is also imperative. Firstly, the success rate of interventions is shown to be impacted by the age of support, with greater improvement being seen in younger age groups (Oerbeck et al., 2014). Secondly, whilst some professionals believe that SM is something that a child will 'outgrow', this is arguably not the case (Johnson & Wintgens, 2017). Without the appropriate treatment there may be continued reinforcement of behaviour (Shipon-Blum, 2007), and a child with SM may continue to be non-verbal into their adolescent years, and in extreme cases it can persist into adulthood. Furthermore, whilst an individual may naturally develop coping strategies to resolve the core symptom of SM, lifelong difficulties can remain for these individuals. A lack of support can result in social withdrawal, self-harm, depression, social anxiety disorder, and school refusal in the teenage years (Johnson & Wintgens, 2017). There are very few longitudinal studies exploring the wellbeing of individuals in their adult years, that had a diagnosis of SM in childhood, but those that do exist indicate that without the appropriate support, substantial latent problems with communication, mental health, cognition, underachievement, and lack of independence can occur (Remschmidt et al., 2001). Early intervention requires early identification, and in order for SM to be identified early, practitioners need to have knowledge of SM. Case studies indicate that school staff often know little about SM (Khan & Renk, 2018; Reuther et al., 2011), which is understandable due to its rarity, however they are in a unique position to be able to identify SM early given it's prevalence in the school environment (Kovac & Furr, 2019), and their knowledge of SM and confidence supporting children with SM could be effectively improved with the appropriate training (Harwood & Bork, 2011).

Alongside the more well-evidenced impact of anxiety and environmental influencers on SM, this essay has identified some of the individual differences that emerging research indicates may be present for some children with SM, suggesting that the scope of the condition is likely broader than has previously been determined. SM is a heterogenous condition and there is a need to take a holistic approach by identifying both the environmental factors and the individual differences that may be contributing to SM. A multimodal approach to supporting children with SM can then be taken, involving parents, school staff, and other professionals such as speech and language therapists, when needed. Whilst the incidence rate for this vulnerable group is reportedly low, research points towards a significant and debilitating impact if not supported effectively. As has been noted throughout this essay there is a substantial need for more robust research to clarify the individual differences that are present within children with SM, as well as to evidence effective ways of addressing these needs. Whilst the already existing literature can help guide a holistic exploration of needs, there is not currently an empirically validated approach to supporting SM and without further evidence, the most effective way forward for addressing individual needs and supporting this vulnerable group can only remain theoretical.

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