



## Case Studies from the Child Development Center

Inside this issue:

*Selective mutism  
is more than  
shyness*

### Selective mutism is more than shyness

*Robert Schum, PhD, clinical psychologist, Child Development Center, Children's Hospital of Wisconsin; professor, Pediatrics, Medical College of Wisconsin.*

FC was a 5-year-old girl who had been in kindergarten for three months and was not talking to her teachers or peers. During the previous school year, she attended preschool two mornings a week, where she had participated in activities but did not speak. Now, the kindergarten staff was concerned about her lack of speech and their inability to assess her academic progress. FC's parents brought this up with her pediatrician, who referred her to the Child Development Center for evaluation.

FC is the oldest of two children in her family. Her mother's pregnancy was uneventful, and FC was a term baby with no birth complications. She met all her developmental milestones at a typical rate and was a healthy child with no significant accidents, illnesses or injuries. She seemed shy during check-up appointments with the pediatrician but passively cooperated with examinations.

At home, FC was affectionate and playful with her parents and 2-year-old brother. She chatted with her parents, played with her brother and liked to have her parents read to her. Oftentimes she was exuberant and boisterous in play with her brother, such as when they chased each other around the house. FC had a history of being somewhat shy or timid outside her home. For example, she talked to one grandmother, but not to her other three grandparents. Her parents knew she was shy in preschool, but she seemed to enjoy it. When she came home from school, she showed her parents her artwork and sang songs she learned. Her parents had expected her to become less shy in school once she attended on a daily basis. However, after three months she had not improved.

During the psychological evaluation, FC played quietly with toys while her parents conversed with the psychologist. FC showed pretend play with a dollhouse. She did not talk with her parents, but seemed to be listening to the adult conversation. Mr. and Mrs. C reported that their daughter always had been shy in social situations. She never wanted to sit on Santa's lap at the mall and did not like to pose for family pictures. At family parties, she liked to watch her older cousins play but did not talk to them. She often was timid in new settings, such as going to a fair or carnival. Both parents were

shy as children, but neither of them was completely silent like their daughter. In college, Mrs. C experienced some anxiety symptoms and benefited from a brief course of medication and counseling.

In the evaluation, FC quietly cooperated with the psychologist. She pointed to pictures during measures of nonverbal cognitive ability and receptive vocabulary. She performed within an average range on both measures. She soberly watched the psychologist demonstrate several toys to her, but she did not manipulate them herself. She faintly nodded and shook her head in response to several questions about favorite foods and cartoon characters.

Based on the evaluation, FC was diagnosed with selective mutism. She began psychotherapy on a schedule of two sessions per month. Within several months, she had learned to point to choices, nod and shake her head clearly, and started drawing pictures to demonstrate events and interests. As she made progress with these forms of communication, her therapist coordinated activities with the kindergarten teacher to help FC generalize her communication skills to the classroom. The psychologist also consulted with school staff regarding alternative methods to assess FC's academic progress. FC continued therapy for two years, during which time she slowly expanded her communication repertoire to include speaking to family members, speaking to peers, and finally speaking to teachers.

### Discussion

Selective mutism is a psychological disorder that affects approximately 7 in 1,000 children. The female to male ratio is approximately 2 to 1. The prevailing opinion in professional literature is that it represents a variation of a social anxiety disorder. The recommended treatment approach is cognitive-behavioral therapy with a mental health specialist. There are a number of case reports regarding the use of medication to treat this disorder. However, there are only a few controlled studies on the efficacy of medication, and the results indicate only modest success. There is a strong familial relationship between children with selective mutism and parents with a history of anxiety disorders.

## Selective mutism is more than shyness, *continued*

Response to psychotherapy is highly individual. The focus of therapy is typically on expanding different methods of communication and situations in which the child is comfortable. Some children respond quickly to therapy, and other children require more prolonged periods of therapy to overcome their anxiety.

The most common concurrent behavioral problem is oppositional difficulties at home. However, selective mutism is not considered an oppositional disorder. Some children will be defiant of their parents, particularly if their parents make strong demands for performance or compliance. In addition, another concurrent condition is resistance to using the toilet, occasionally at home and more often in public situations, including school. When toilet refusal occurs, the psychotherapist usually has to make this the first priority in treatment, before talking, so that the child is able to use the toilet at school. Several studies, as well as clinical experience, indicate that a single traumatic episode rarely is the impetus for selective mutism. Rather, the mutism appears to be a symptom of a long-standing anxiety disorder.

This case illustrates a common presentation of selective mutism. It often is misinterpreted as simple shyness or

timidity, and usually doesn't become more clearly identified until the child starts school. Diagnosis by a specialist is based upon behavior and history, and usually is not complicated. The specialist needs to rule out other explanations for the mutism, including different languages or cultures, as well as developmental disabilities, including autistic spectrum disorders, speech/language disorders and learning problems. The most discriminating feature of selective mutism is that children speak fluently within their home but not outside it. These children typically respond well to psychotherapy, with little remission once they start speaking in school.

### References

Cohan, S. L.; Price, J. M.; and Stein, M. B. (2006). *Suffering in silence: Why a developmental psychopathology perspective on selective mutism is needed.* *Developmental and Behavioral Pediatrics*, 27 (4), 341-355.

Schum, R. (2006). *Clinical perspectives on the treatment of selective mutism.* *Journal of Speech-Language Pathology and Applied Behavioral Analysis*, 1 (2), 149-163. <http://www.behavior-analyst-today.com/SLP-ABA-VOL-1/SLP-ABA-1-2.pdf>

*Case Studies from the Child Development Center* is a limited edition newsletter to help inform referring physicians and other professionals on the depth and breadth of pediatric communication and behavioral issues diagnosed and treated in the Child Development Center at Children's Hospital of Wisconsin.

It is written by Child Development Center staff and produced by Children's Hospital of Wisconsin in January, March, May, July, September and November.

It also is available online at [www.chw.org/childdevelopment](http://www.chw.org/childdevelopment), Related Links.

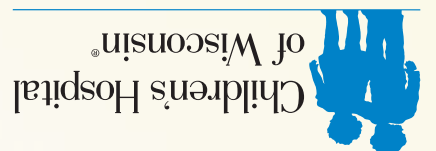
Questions and suggestions can be forwarded to:

Mark Simms, MD, Child Development Center, MS 744,  
Children's Hospital of Wisconsin, PO Box 1997, Milwaukee, WI 53201-1997, or call (414) 266-2928.

©2007 Children's Hospital and Health System. 6.5K 0907 Printery

Milwaukee, WI 53201-1997  
PO Box 1997  
Child Development Center, MS 744

*A member of Children's Hospital and Health System.*



NON-PROFIT  
ORGANIZATION  
U.S. POSTAGE  
PAID  
MILWAUKEE, WI  
PERMIT NO. 2284