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Clinicians Perspective on Interventions Most Effective in Working with Selectively Mute Children

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Clinicians Perspective on Interventions Most Effective in

Working with Selectively Mute Children

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MSW Clinical Research Paper

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Abstract

Children with selective mutism (SM) within the school setting bring forth a unique and challenging set of characteristics and issues for teachers and support staff. Children with selective mutism have an overwhelming fear of being seen or heard speaking, which presents as a challenge in assessing students for knowledge and content within the school setting (Perednik 2011.) There are many different causes for general mutism such as trauma, severe neglect, foster placement, etc. However for the purposes of this paper, selective mutism is the sole focus which effects young people. Selective mutism is categorized as an anxiety disorder and a variant of a social phobia (Black & Uhde, 1992). This qualitative study explored professional clinician's ideas about interventions and strategies that are most effective in working with selectively mute children. Interventions within the school setting and how those interventions are informed and utilized amongst support staff and teachers to support children with selective mutism in overcoming their fear of speaking outside of the home is the main focus within this research. Using qualitative interviews, information was gathered about professionals' perceptions of best practice interventions used with selectively mute children. This research contributes to enhanced knowledge and confidence among educators in addressing children's unique needs with selective mutism through the use of behavioral and cognitive behavioral techniques, psychodynamic, family systems, multimodal, and psychopharmacological interventions that were suggested for work toward overcoming this disorder. The research proved that there is a vast amount of literature that already exists, however there is a lot of education that is still needed in order to be effective in teaching children with selective mutism. The research supports a need for professional development and psychoeducation for classroom teachers, special educators, speech clinicians, school social workers, and support staff.

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To the practitioner's I interviewed, this project's foundation is created upon the genuine, heartfelt insight, and truthful reflection of what it takes to work with those with special needs who need our support and understanding. We do this through building relationships one student at a time! Thank you!

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Introduction

Selective Mutism (SM) is a psychiatric disorder of childhood characterized by consistent

failure to speak in specific social situations despite speaking in other situations (American

Psychiatric Association, 1994). In the DSM-IV, the disorder was changed from "elective

mutism," to selective mutism. The diagnostic criteria was slightly modified to include selective

mutism as its own diagnosis within the anxiety disorders category. In certain settings, such as

the home or when they are alone with their parents children speak freely, however within public

situations such as school, they become mute (Schum 2006). Traditionally, selective mutism has

been minimized as simply being shy or has been treated as a negative behavior that can be

controlled by the child, thus the child often receives punishment for such behavior (Cunningham

et al., 2004).   Because the behavior is not acknowledged accurately, the child is forced to

attempt to regulate on his or her own without any assistance. This often results in the child

becoming more silent to keep the anxiety contained while they are outside of the home (Moldan,

2005). The onset of selective mutism typically begin between the ages of three to five years, or

when entering preschool. However it is noted that treatment is most commonly started between

the ages of six and 11, when a child enters the elementary school system (Hung, Spencer,

Michael, Dronamraju, 2012). Children with selective mutism are at risk for deficit in a number

of areas such as speech and language, social functioning and academic functioning when

compared to their non-selectively mute peers (Bergman, Paicentini, McCracken, 2002).   Anxiety

in the form of shyness, timidity, and social withdrawal are reported as common symptoms with

children with SM (Black, Uhde, 1995). It is speculated that children with selective mutism may

be actually attempting to self-regulate internal anxiety and other emotional states in at least a

portion of children with SM (Moldan, 2005). The correlation between children with selective

mutism who have a parent with selective mutism is high. According to Black and Uhde (1995),

70% of parents report through a family history as having social phobia, and 37% as having

selective mutism as a child themselves. It is important for school social workers and support

staff to understand the importance of family involvement in the assessment of selective mutism

because of the correlation between a parent having social phobia as an adult and a child having

selective mutism. This is seen as a predictor of future social phobia for children with the

disorder (Chavira, Shipon-Blum, Hitchcock, Cohan, Stein, 2007).   Although selective mutism is

a rare disorder of childhood, it is more pervasive among girls, and is seen across all economic

classes (Steinhausen, Juzi, 1996). Selective mutism is found to be prevalent in about 8 in 10,000

as suggested by other studies (Brown and Lloyd, 1975; Fundudis et al., 1979).

   The problem: Selective mutism interferes with a child's social and emotional

functioning mainly within the school and community environments and can be a predictor of

future social phobia and anxiety well into adolescence and adulthood (Cunningham, 2000).

Early intervention is hoped is to increase social integration and success in the individual's life.

Children who struggle with selective mutism have been shown to have issues with peer

relationships/interactions, the ability to connect with school teachers and other staff, academic

success and the ability to cope with school altogether; bringing about issues with truancy which

exacerbates the separation from peers and compounds the problems of achieving academic

progress (Cunningham et al., 2004). Given the connection between parental and child selective-

mutism, treatment and strategy efforts must look at intervention that includes parents and

children together, as well as interventions that professional clinicians may be using that can be

taught to school personnel in order to support children with selective mutism (Garet et al., 2001).

   The primary purpose of this paper is twofold. First, to examine the kinds of

interventions/strategies that are being used by professionals who are working with children with

selective mutism and second, to better understand how those treatments assist with self-regulation, and the development of a supportive regulatory system that listens to the non-verbal cues of the selectively mute child. Previous research has indicated that treatment should contain an educational component that empowers all adults in a child's world with selective mutism (Cunningham, et al., 2004) Creating a foundation of understanding regarding environment for understanding regarding selective mutism as an emotional behavior is of utmost importance. For the purpose of this study, the term "professional" within this research study will be used to describe school social workers, clinical professionals, and co-located therapists. Co-located therapists are professionals contracted to provide clinical work within schools. This research study focused on seven specific areas of inquiry underneath the two overarching questions outlined above. Those seven areas of inquiry were: 1) The interventions/strategies that "clinicians" use with students who have selective mutism 2) The interventions/strategies that have been found to be the most effective with helping students overcome characteristics of selective mutism 3) The extent to which clinicians have parental involvement when working with selectively mute students 4) The degree to which clinicians aware of the history and background of parents with selective mutism and social phobia 5) The means of educating parents used to create success for students within the general education setting 6) The means of educating school personnel that are used to help children with selective mutism succeed within the school environment 7) The extent to which the school is involved in therapy involving children with selective mutism? This study is intended to contribute to the learning and success rate and generalization of skills of not only clinical social workers, but other professionals working with children who have selective mutism within school settings.

Literature Review

This literature review focused on gaining an understanding of selective mutism (SM) and the unique challenges the disorder presents, along with strategies and interventions that may be taught to educators in supporting children with selective mutism within the school system. In turn, this work contributes to the increased knowledge that is used by professionals and educators in supporting and addressing the needs of children with SM within the school system. Research informs future professional development needs of teachers, school social workers, and support staff within the educational system.

Selective Mutism

Within the DSM-5, "selective mutism is characterized by a consistent failure to speak in social situations in which there is an expectation to speak (e.g., school) even though the individual speaks in other situations. The failure to speak has significant consequences on achievement in academic or occupational settings or otherwise interferes with normal social communication." (American Psychiatric Association, 2013).

Diagnostic criteria include symptoms being present for at least a month, not including the first month of school, the inability to speak not being due to lack of knowledge, or comfort with the spoken language within a social setting, or being better explained by a communication disorder, and is not due to another psychotic disorder (DSM-5, 2014). Features of selective mutism that support a diagnosis include oppositional behavior, temper tantrums, negativity, clinging, withdrawal, social isolation, excessive shyness, and fear of social embarrassment (p. 195). Other common features within the diagnostic process include, a lack of speech in social interaction with adults or children in social settings, yet the child will speak in their home in the presence of immediate family members but not in front of other relatives or friends of the family

(DSM-5, 2014, p. 195). Children with selective mutism are symptomatic with regard to speech

and language, social functioning and deficiencies in academic functioning as compared to their

peers (Bergman, Paicentini, McCracken, 2001). Selective mutism is often diagnosed before the

age of 5, although the disorder may not gain clinical attention until the child enters school (Hung,

Spencer, Michael, Dronamraju, 2012). It is thought that children will "outgrow" the disorder,

although selective mutism is still seen in adulthood, as the diagnosis is changed to that of Social

Phobia in early adulthood(Chavira, et al 2007).   Those with social anxiety disorder who also

suffer from selective mutism may experience symptoms of selective mutism going away as they

grow, yet symptoms of social anxiety persist (Black, Uhde, 1995). SM is thought to be a rare

disorder that has not been included in many epidemiological studies, therefore little is known

about the prevalence. Clinic and school samples would estimate the range of prevalence to be

between 0.03% and 1% of children between the ages of three to five years of age. One study

found that the prevalence of selective mutism to be eight in 10,000 (Brown and Lloyd, 1975;

Fundudis et al., 1979; Gergman, 2000; Lindsey, Piacentini, and McCracken, 2002), however 2

studies done in the late 90's suggest the disorder is more prevalent (Kopp and Gillberg, 1997;

Kumpulainen et al., 1998). This disorder does not seem to differ by gender, race, or ethnicity

according to recent information although many studies from the past have looked to identify

these statistics and have found that there seems to be a higher prevalence among females than

males, and that bi-lingual and immigrant children tend to have a higher rate of diagnosis (DSM-

5, 2014; Steinhausen, Juzi, 1996).

Characteristics of the disorder

Selective mutism is characterized by excessive shyness, as observed by a blank facial expression, lack of smiling, staring into space, "deer in the headlights" look, frozen appearance, awkward stiff body language (Moldan, 2005, p. 295). The child has a fear of social embarrassment, may not engage in eye contact, nod or shake head, smile when attempting to answer questions as a part of this disorder (Perednik, 2011). The child may exhibit social isolation and withdrawal, being shy, or slow to warm up to new people or new situations (Perednik, 2011). Children who have selective mutism may be mildly to moderately uncomfortable in all social situations, have compulsive traits such as having to play with certain toys or be in certain areas of a room for comfort, be negative about many things in life, or exhibit temper tantrums in place of speech. The child may disguise speech/voice, may have difficulty initiating nonverbally or responding nonverbally, and may be slow to respond (Middendorf, 2013).

Children with SM typically refuse to speak at school, which often leads to the teacher's inability to assess skills such as reading. Often children with SM will use nonverbal language skills to communicate. Pointing, shaking the head yes or no, grunting, or sometimes whispering to a peer and eventually with the teacher (Perednik, 2011).

Wright et al. (1995) describes children with selective mutism as "oppositional" in behavior as the ability to speak increased in a study, indicating the presence of self-regulation issues being a significant issue needing to be addressed for children with SM (p.858). Still, others (Elson, Pearson, Jones, & Schumacher, 1965) describe selective mutism as being a way that a child copes with a state of serious anxiety that causes negative and provocative behavior.

Causes of selective mutism

Anxiety in the form of shyness, timidity, and social withdrawal is thought to be at the root of selective mutism (Black, Uhde, 1995). The correlation between children with selective mutism who have a parent with a social phobia is high. According to Black and Uhde's study (1995), 70% of parents of selectively mute children report having social phobia, and 37% as having selective mutism as a child themselves. There is also speculation that selective mutism may be an indication of an inhibited temperament as shown through shyness, social isolation, and social anxiety (Dow, Sonies, Scheib, Moss, & Leonard, 1995). Speech clinicians on the other hand believe that selective mutism has a direct correlation to developmental delays within speech and language (Schum, 2002).

According to Ruth Perednik, the author of The Selective Mutism Treatment Guide, A Manual for Parents, Teachers and Therapists (2011), the causes of selective mutism may fit into one of three groups: Predisposing factors, triggers, and maintaining factors. **Predisposing factors** include psychological and physiological causes as factors. The child's shyness, timidity, hyper-sensitivity, having a family history of anxiety or SM, anxious modeling by a parent, an expressive language impairment within speech, being bi-lingual or disconnected from the primary culture, or having a cognitive delay. **Triggers** may include events like starting school, moving frequently, moving to an area where the primary language is different, or being bullied, shouted at or mocked as a reaction to the child's talking. **Maintaining factors** include being isolated socially from family members, being misdiagnosed (oppositional behavior disorder, autism, mental retardation), lack of understanding by teachers, families, and psychologists, reinforcement due to increased attention on the lack of speech, or heightened anxiety caused by pressure to speak. Questions that highlight or draw attention to the child's symptoms, (e.g.,

"what's the matter?", "Why are you not speaking to me when I talk to you?") which is a behavior meant to keep adults away, yet causes quite the opposite scenario for children with SM as the adult persists and intrudes with more questions (Moldan, 2005). Reinforcement or "enabling" the selective mutism by parents who feel the child's anxiety and thus speak for them in social settings can play a part and maintaining factor for the selectively mute child (Perednik, 2011).

Selective mutism is not due to a child being stubborn. SM has nothing to do with being traumatized, being deliberately defiant, or due to a speech and language disorder. Selective mutism is not normal shyness that will be outgrown (Schwartz et al., 2006; Standart & Le Couteur, 2003).   The difference between selective mutism and shyness can be attributed to the fact that SM is found in specific selective settings, whereas shyness is consistent across settings, and that SM children are only verbal in one or more settings, verses shy children are quiet, but can speak when they need to communicate.

Etiology. There was a previous philosophy that selective mutism was related to past trauma, or an overly protective mother, or an overly strict father (Middendorf 2013). The current philosophy is in line with the current DSM-5 diagnosis falling within guidelines for a social anxiety disorder (Irizarry 2015). Studies have shown that there may be a genetic link, as many children with selective mutism have a parent who has social inhibition, or because of the significant overlap between selective mutism and social anxiety disorder, there may be shared genetic factors between these conditions (DSM-5, 2014).

The social structure of the family and socialization patterns within the family unit may also be contributing factors that intensify or allow maintenance of the disorder of selective mutism (Jackson, Allen, Boothe, Nava, Coates, 2005). Moldan (2005) conducted a study that

indicated that selective mutism is an attempt to self-regulate internal anxiety and other internal

emotional states in at least a portion of selectively mute children. In this study, self-regulation is

focused on in order to gain information about the child's ability to adjust arousal appropriately so

that the SM child eventually has the ability to directly express emotions that were previously

thought to be strictly behavioral in social situations.

Related conditions.

Related conditions include Obsessive compulsive tendencies, a sensitivity to touch and

noise, poor body awareness, may be a candidate for occupational therapy for sensory integration,

and anxiety type behaviors (chewing on fingers, clothing, breaking pencils, constant erasing,

etc.), (Diliberto, 2014). Speech and language concerns play a role with about one third of

children with SM, while separation anxiety during infancy through preschool effect about three

quarters of children with SM (Moldan, 2011). Sleeping and eating problems are also quite

common as well as social phobia, behavior disorders and anxiety along with problems of

elimination are found to be co-occurring conditions within the selectively mute population

(Bergman, Paicentini, McCracken, 2002). Children with selective mutism are symptomatic with

regard to speech, social anxiety, and internalizing (Diliberto, 2014). According to Steinhauses

and Juzi (1996), it is not unusual for selectively mute children to improve with treatment, and for

the diagnosis to change from selective mutism to social phobia as they enter adulthood. **Types**
of therapy being used to treat selective mutism

There are many different forms of therapy being utilized for the treatment/intervention of

selective mutism. Language clinicians, psychologists, and psychiatrists have similar yet unique

slants to therapy approaches within this disorder. Psychologists and psychiatrists typically use a

behavioral or cognitive behavioral approach and psychopharmacological interventions. Whereas

language clinicians, such as speech pathologists use a behavioral language training approach (Schum, 2005). There is some overlap in services provided due to conflicting beliefs about the roots of the disorder (Black, Uhde, 1995). The research seems clear however, that regardless of the roots of the disorder, effective intervention must involve contact with a psychiatrist, psychologist, the teacher, and parents (Ponzurick, 2012).

Dyadic regulatory system, cognitive-behavioral approach, modern psychoanalytic interventions, family systems approach, psychodynamic approach, and multimodal approaches that also utilize dyadic regulatory systems work are among the most effective treatment recognized within the psychological field for this disorder (Watson, 2011). Some studies found that there was a need for psychopharmacological interventions within treatment of selective mutism when a child's anxiety did not allow for any progress within the clinical, community, and school based settings (Jackson et al., 2015)**.**

Dyadic regulatory system approaches. Treatment, no matter what form, has been found to involve the development of a dyadic regulatory system that takes the non-verbal cues of the selectively mute child and translates them into responses. It is thought that listening to and acknowledging of children by caregivers assists in the development of self-regulation for those children with SM who exhibit aggression (Fonagy, 1999; Sroufe, 1983).

Cognitive-behavioral approaches. Cognitive behavioral researchers note the benefits of using graduated exposures to anxiety provoking situations as a way to provide methodical, progressive, and efficient contact with situations that provoke anxiety, starting with something that has the least anxiety stimuli to the most provoking stimuli (Beidel & Turner, 1999; Cunningham, 2000). This type of therapy is described as starting in a situation where the child speaks most comfortably, gradually increasing in small increments, moves to different locations

while keeping the child speaking. Within this approach, it is believed that anxious children need to begin where there is some success in order to tolerate the small doses of anxiety as the hierarchy increases with people, places, and activities (Giddan et al., 1997).

Integrated behavioral therapy with exposure activities has also shown promise in working with selectively mute children (Bergman, Gonzalez, Piacentini, & Keller, 2013). According to the National Association of Speech Clinicians, selective mutism should be treated in conjunction with a speech-language pathologist, a pediatrician, a psychologist, and frequently with a psychiatrist (Keen, Fonseca, Wintergens, 2008; Ponzurick, 2012).

Labbe and Williamson (1984) described behavioral interventions that include contingency management and stimulus fading as parts of intervention. **Contingency management** involves receiving positive reinforcement for verbalizations and non-reinforcement of non-verbal requests, like when gesturing or pointing for something communicated about. This technique involves a reinforcement that has meaning for the child and using the reinforcement consistently when verbalization occurs. **Stimulus fading** is a behavioral intervention that involves gradually adding to the situations that the selectively mute child will speak. This is a very gradual process that involves a great deal of time and energy as it involves expanding the number of people and places in which the child will speak, starting with a dyad that the child is comfortable with.

Modern Psychoanalytic Interventions. Hyman Spotnitz (1987) developed the approach of studying the understanding of silence and the purpose it serves the client. The purpose of this therapy is not in getting the child to speak, but rather in determining the motivation and understanding of meaning behind silence, thus employing joining and mirroring techniques (Moldan, 2005). Margolis (1994) described these two techniques as a form of communication

where the therapist gives the client the feeling that they agree with them. **Joining** may look like

telling the child that being silent is a good thing if it helps them not to feel too scared or

embarrassed when at school. **Mirroring** is the technique of matching the feeling state of the

client as the therapists own feeling. Both of these techniques are thought to create a tension-free

environment where the child can feel comfortable. Although communication is often not in

verbal form in this type of therapy until the end stages of therapy, other forms of communication

are considered "progress", such as in increased eye contact, initiation of play activities, nodding

of the head, or shading to indicate wants during a session (Moldan, 2005).

Family systems approach. There are multiple family approaches used in the treatment

of selective mutism. One approach found to be highly successful is called: "Group therapy for

selective mutism-A parents' and children's treatment group" (Irizarry, 2015). A study by

Sharkey, et al., (2008) found that it had the most success in the treatment of selectively mute

children and their parents within a group therapy setting. In this particular study, eight 90-

minute educational lessons were provided to parents on how to manage SM in everyday life.

Parents were taught how to alter their behavior to effectively increase the child's confidence.

This study revealed a 97% success rate as measured by children's' diagnosis of selective mutism

being lifted as a direct result of the training/intervention from the program.

Relevance to Social Work Practice in Schools

There is a clear need for education within schools with regard to selective mutism and the

promoting of skilled clinical treatment with children and families who suffer from the symptoms

of the disorder. Giving information for available treatment options and avenues in which to

support families seems to be of utmost importance to successfully overcome the disorder.

According to Perednik (2011, p.17), once the child is comfortable speaking to the therapist in

school, the generalization stage of broadening the child's speaking habits to include as many

people as possible begins. School social workers and educators need to maintain a relevant base

of information on treatment measures that are proving to aid families and children most

effectively in order to provide top tier care for clients that eliminate the symptoms. Interventions

kept the lighter and natural, the better according to Perednik (2011) as all staff learn to stay with

a playful tone, the more effective the school environment will be in lowering the child's anxiety.

Because each client is different, having advocacy for clinical work within the school setting will

allow families to learn the importance of clinical treatment with selective mutism, and the ability

to make educated decisions about the kind of strategies/treatments that are available. Harwood

& Bork (2011) stated that given the complexity of selective mutism, and its impact on the

learning environment, and the challenges inherent in addressing the needs of children with SM in

the classroom, perhaps targeted professional development is essential to the success of learning

and children with selective mutism. This work also focused on the use of social stories, seating

arrangements, physical layout of the classrooms, and visual cueing systems being consistent

across settings and professionals within the school setting.

Conceptual Framework

For the purpose of this research study, an empowerment framework was used as

applicable to this work as it depends on a collaborative relationship that deals with shared power

and the human struggle (Lee, 1994). Empowerment theory arose out of the strengths perspective

and strengths-based approaches for offering service (Adams, 2008). Empowering skills builds

motivation. As needs are being met by client and worker through gaining resources and

opportunities that attend to the problem, clinicians are able to keep hope for their client to be free

from selective mutism alive. Empowerment is consistent with a collaborative approach to

serving client self-determination and the interconnected levels of living (personal, interpersonal, and communal) are needed as never before in dealing with selective mutism due to the multitude of service providers involved for clients (Lee, 1994, 2001). There is a wide variety of related empowerment-oriented conceptualizations within the strengths based perspective in line with the treatment of selective mutism (Adams, 2008; Hudson, 2009; Eamon, 2008).

Empowerment practice must take into account awareness of interdependence among systems according to Lee (2001). Lee's (2001) article of The Empowerment Approach: Building the Beloved Community deals with empowerment across the lifespan individually and in families, groups, and communities to develop the capability and assets that bring about change for clients. "Empowerment is holistic and non-hierarchical. Empowerment is about taking control, achieving self-direction, seeking inclusiveness rooted in connectedness with the experiences of other people. It concerns individual achievement and action. One aspect feeds another" Adams (2008 p. 18).

Empowerment deals with a block in problem-solving that stigmatizes the identity (Solomon, 1976). Alleviating isolation and loneliness is only part of the goal when empowering families, schools and mental health to work together for the betterment of the child suffering from selective mutism.

Children whose parents and educators are involved in treatment make more progress developmentally within programs designed to meet their needs according to research (Brenton, 1994). Research findings also suggest that where there is high importance placed on parental involvement for children with selective mutism. There is a clear need for early intervention with program staff to be involved and encouraging parental involvement. These findings are important to intervention and to share with school systems supporting and working with

selectively mute children. Empowerment can be seen from many different angles. First with

parents and how they interact and support their children through the overwhelming anxiety

experienced through going to school as well as through understanding and empathizing with the

child's plight (Boyd, 2010). According to Boyd, parents empower children as they themselves

are empowered in navigating the maze of intervention within mental health right along with the

child. Understanding that mental health does not automatically mean the use of medication that

many parents are fearful of for their very young children has been empowering as well.

Empowerment of teachers, special education staff, support staff, etc. is important to be

experienced and listened to as the therapist and school personnel work together as a team to

support the child and family in overcoming selective mutism.

Methods

Research Design

The purpose of this study. The first, to examine the kinds of interventions/strategies that are being used by professionals who are working with children with selective mutism and second, to better understand how those treatments can assist with self-regulation, and the development of a supportive regulatory system that enables success for children with selective mutism within the school environment. Semi-structured qualitative interviews were used in order to discover philosophy and/or theoretical approaches used when working with students with selective mutism, Intervention/strategies they feel have been most effective in helping students to overcome characteristics of selective mutism, parental involvement that may or may not influence therapy with those with selective mutism, and how clinicians involve the school (teachers, support staff, special educators, etc.) in developing a treatment plan for students within the educational setting who have selective mutism. The researcher was committed to find recurrent themes through the interviews that speak to the experiences of those who work most closely with people with selective mutism.

Participants

Participants were recruited through a snowball sampling research design which resulted in eight semi-structured qualitative interviews. A qualitative design was used for this study to allow participants to answer questions based upon their professional experience. The researcher started recruitment by asking several clinical social workers with firsthand experience working with selective mutism to participate in the study. The participants were then asked to refer other participants. Phone contact and e-mail was then developed and sent to prospective interviewees already known to have worked with clients that have selective mutism.

A convenience and snowball sample was used for this study resulted in eight

professionals working within school settings being interviewed. Some of the professionals were

employed by the schools themselves, and some were contracted by the schools to provide on-site

services and were known as Co-located social workers. All eight participants were female, and

the experience level of each participant ranged from being in their first year of practice to thirty

five years of experience working in schools as a human service professional. Although titles

ranged from school social worker, to co-located therapist, to human resource practitioner, to

clinical social worker, all had similar experience in working with a small number of clients with

selective mutism. Some professionals had experience with only one student with selective

mutism, others had experience with six or more students.

Data Collection

Once participants agreed to take part in this study, interviews were scheduled for a time

and location of their choosing. Each interview took approximately 55 minutes. The interview

consisted of ten questions with several probing questions which were developed after careful

review of previous literature regarding practices with selectively mute clients. The primary

interview questions asked the participants to discuss their professional experiences when

working with selectively mute clients, their families, and school personnel, and their thoughts on

providing responsive practices in the field (see Appendix A for complete list of interview

questions).

Field notes were used during the interviews after reviewing Berg's (2009) research about

how to take notes properly and document. The field notes method was used for one face-to face

interview for this study. "Cryptic jottings" method was utilized as notes were taken during the

interview process itself. Brief statements regarding body language, facial expression for cues,

and other notes were made that are not picked up from the audio recording were used which helped with interpreting the notes after the interviews were completed.

Protection of Human Subjects

The protection of all participants was be ensured through the approval from the Institutional Review Board (IRB) at St. Catherine University. A Collaborative Institution Training Initiative (CITI) was required prior to the research approval by the IRB. This training focused on the protection of human subjects and is widely accessed by academic institutions to ensure adequate information to researchers. Individuals interested in participating in this research study were provided with background information on the study's focus, description of interview questions, research procedures, risks and benefits prior to participating in this study to ensure protection of confidentiality. Consent forms were emailed to participants for review prior to the interview and a signed copy was gathered prior to the start of each interview. Subjects were asked their understanding of the informed consent process. In order to maintain the confidentiality of the subjects, only the researcher had access to the names and other identifying information. All participants were offered the ability to choose where the interview was be held and at a time convenient to them. The main interview questions were generally related to the participant's experience with their work as professionals who work with selectively mute children. The participants were instructed that at any time they were free not answer a question or end the interview without consequence.

Participant's confidentiality was assured by not using any identifying information during the recording and transcription of the interviews. All transcripts and voice recordings were locked on a password protected file on the researcher's personal computer. Audio files once

transcribed were deleted. Consent forms will be stored in a private file in the researcher's home

until May 31st, 2016 at which point they will be destroyed.

  The interviews were recorded with the use of an audio recorder, then transcribed with a free

online application to transcribe data and three interviews were transcribed by a paid professional

transcriber who signed a confidentiality agreement. All data was utilized for further data

analysis. The researcher's contact information was given to the participants for any further

questions and follow up participants may want in regard to this study.

Data Analysis

Interview transcripts were coded, and searched for themes that repeated across

interviews. Transcripts were coded again by a peer to aid in gathering themes that may have

been missed by the researcher. Data analysis involved allowing themes to emerge from the

interviews through a grounded theory approach. Grounded theory states that meaning can be

drawn out of the data rather than from existing theories or hypotheses; it involves a "continual

interplay between data collection, data analysis, and theory development" (Monette, Sullivan, &

DeJong, 2011, p. 225). Interviews gathered information about the experiences of professionals

having worked with selectively mute children through their own words. As themes were

discovered across interviews, new theories emerged and implications for social work practice

were drawn.

Findings

The findings are based on qualitative interviews describing the experiences of eight

mental health professionals within school systems with experience working with students

diagnosed with selective mutism. The interviews examined the kinds of interventions/strategies

that are being utilized as treatments to assist with self-regulation, and the development of a

supportive regulatory system. The two main questions answered when looking at the kinds of

interventions/strategies that are being used by professionals who are working with children with

selective mutism and to better understand how treatments assist with self-regulation, and the

development of a supportive regulatory system that listens to the non-verbal cues of the

selectively mute child.   Effectiveness seems to be an elusive term from the findings within this

study, as each of the professionals interviewed saw each child as an individual case with similar

yet very different intricacies that required a plan that would prove to be unique and individual in

nature. Types of intervention, length of time needed for intervention and lasting effects of the

intervention were found to be completely individual to each child.   However there were similar

themes that emerged from the research. The development of relationship and providing a safe

and comfortable environment for students with selective mutism stands out when answering the

overall research question regarding effectiveness of interventions.

Six major themes emerged from the semi-structured interviews and are listed as follows.

The themes include 1) treating selective mutism as an anxiety disorder or Language Impairment,

2) creating an environment of safety, 3) intervention and teacher support, 4) school mental health

services, 5) parent involvement/support, and 6) staff development. Each one of these themes will

be explored in turn, below.

Treating Selective Mutism as an Anxiety Disorder or Language Impairment

The first theme that was gathered from the data included a debate about what category

children with selective mutism should be serviced under. Traditionally and in the past these

students were seen as having a disorder of speech, therefore the speech clinician was charged

with servicing these children according to all but one of the interviews conducted. One social

worker said that a reading specialist volunteered for the task of working with a selectively mute student because no one else in the district was willing to take on the job of working with the boy who would not speak.

> No one really knows who to refer a child who doesn't speak to. I believe that selective mutism is like an anxiety disorder. The child is so fearful in the school environment because of all the demands and stimulation that they can't speak. It's not that they don't want to. I will refer parents to outside therapy, but when that doesn't happen for whatever reason, then we are stuck in the school as to who will work with the child having that much anxiety that they can't speak.

The school social workers, co-located therapist, human resource practitioner, and clinical social worker all identified with selective mutism being closely related to an anxiety disorder. A school social worker stated,

> Acknowledging that it is a disorder, first of all, getting the teacher background information and learning that it is caused by anxiety and then working with the teacher to make sure she knows that she must acknowledge the things the child does well. It's not them just being oppositional. It's really about how we as adults respond to the child which isn't just for kids with selective mutism, but can inform for all kids who have mental health issues or emotional issues. And that can be very hard for adult staff to do. We have to change how we are responding and meet the kids where they are at.

As children gain comfort and decide to trust, speaking starts, but without an adequate relationship base across settings, a child who you think has improved may indeed be set up for failure if professionals do not have enough of a knowledge base to realize the need for ongoing, consistent support. One of the school social workers summed this research up quite nicely when she stated,

> These children lack self-confidence. I think it's easiest to alleviate the anxiety and not put a lot of pressure on them to perform particularly verbally. It is more important to establish a relationship with the child and provide a feeling of safety especially in a small group setting. Also, their lack of confidence, they are often afraid that they're going to be wrong but the one thing that I found that's once you've gotten to know them and they are comfortable with you, they really come out of their shells and they share a lot of information. It's super important, I have found that you have to maintain a relationship even when they are doing well academically. The anxiety symptoms do not seem to go away, but academically they are doing well, so the school system puts them back into the classroom environment. I had a boy that this happened to and within three months we were back to where he would not acknowledge anyone with a verbal response…you know it's an ongoing process with them, I think.

The social worker who identified a reading specialist as working with a boy with selective mutism was very concerned about the amount of time that had passed in the child's life before receiving any services for the mutism. She reported that he was in second grade before anyone would help or even knew anything about the disorder and that he felt "lost" in the school environment for so many years.

There was this little boy who had been through two years of preschool, kindergarten, and first grade and had not yet spoken. Everyone knew there was a problem, but no one knew what to do to help the boy. When he got into 2nd grade a team of teachers sat down together with the school psychologist to discuss what could be done, and who could work with the boy, but no one wanted the job. After the meeting, a reading specialist said she thought she could help the boy, and so she started to research and found out that the issue had a name. It was selective mutism. She did more for that boy in one year than anyone had done for him in four years of school.

Creating an Environment of Safety

Creating an environment of safety was by far the most common within the themes as pointed out as necessity to the future wellbeing of the selectively mute child. All eight of those interviewed spoke in different ways about the need for safety and comfort for this population of children. Providing a trusting adult that provides continuity of care throughout the span of education without speech, and continuing for at least a year beyond when speech starts to emerge was considered a part of this theme.

I think the first thing is to establish a relationship in order to alleviate the anxiety and not to put a lot of pressure on the child to perform, particularly verbally. Then I have found it extremely important to follow through with that child at least a year beyond when they start to speak, otherwise with the changes in staff from year to year, I have seen regression. Sometimes putting us right back at square one.

All eight of the professionals spoke in different ways about the necessity for children to have a feeling of safety within the school environment. Because these children are so young, they are just trying to figure out all of the rules at school, and how to work with other children just like everyone else in school. One professional spoke of not wanting to put pressure on the student to speak in any situation when she talked about the use of questioning and allowing the child to simply nod or shake their head in order to answer in order to provide a sense of safety.

Anxiety is huge, along with a lack of self-confidence and the fear of being wrong. Once they get comfortable, they usually come out of their shell, but until then, I never put any pressure on the student to speak. I question in such a manner that they can simply shake their heads yes or no or shrug their shoulders if they don't know the answers.

Another worker stated the following which exemplifies the need for safety before expecting regular speech patterns to emerge.

Mostly, it has been to try to "grow" the speaking situations in which they feel safe and increasing from nonverbal to a whisper, to actual speech. I tend to use this progression, otherwise they just feel pressured by their environment and that only exacerbates the problem.

Another social worker indicated that she uses a ladder approach in her work with children with selective mutism as a means of creating trust and safety before speaking occurs. She stated,

I use exposure techniques to start with. This adds a sense of safety for the child and then start adding one other child at a time to a small group as the child starts to feel comfortable. I let the child invite another child they like from their classroom to start with and we mostly play games because that's where kids are at and most comfortable.

Interventions and Teacher Support

The consensus was clear among all of those interviewed that teachers are an important part of the educational team for children with selective mutism. Many of those interviewed spoke of teachers being frustrated as to what to do and having mis-information about the reason behind the mutism. Six out of the eight interviewed spoke about the need for teachers to have access to teaching strategies in order to be able to assess academic achievement.

> Teachers having some insight into their difficulties, and giving it a name seems to normalize the mutism and let the child know that they are not alone with the mutism that their teacher believes and wants to work with them, knowing they do not have control over the mutism at first. Also, give them permission to speak when they are ready. I used a book called, Understanding Katie that is written from a child's perspective about growing up with Selective Mutism.

Although all of those interviewed employed a variety of intervention strategies while working with students with selective mutism, one thing remained in common – The need for relationship and trust to be built through the intervention process with students having selective mutism. This was the most common of themes among all of the professionals interviewed.

> Working with a teacher and educating them that selective mutism has nothing to do with being defiant is the first thing that needs to be done. So many teachers want to believe that the child is just being stubborn and defiant because they talk at home. Building a relationship that is based on information about the child's needs with selective mutism is so important.

One of the professionals related the use of relationship and acting as if the start of verbal communication is just the way things are supposed to be is highly important based on how children with selective mutism progress through intervention. Testing the safety and security within his environment and the people around him became the central focus for one student as he progressed from silence to a form of verbal communication.

It is important for teachers to know that as kids with selective mutism make progress, they not act with surprise when they do speak. It is common for students to start out using verbal communication through animal noises or whispers, and if everyone acts with surprise that 'hey, Jonny is talking,' it shuts the child down. Children with selective mutism do not like to draw attention to themselves. It causes their anxiety to sky rocket. I once had a student who tested out people's reaction to his use of voice by burping at people. He was testing for over-reaction and whether he was going to pull back again or not.

Another school social worker worked with a student with selective mutism in much the same way as she eased into the speaking world with a student.

I had recordings that I would transfer to the classroom environment for one of my students. We would record his voice making animal sounds at first; which eventually turned into words. Each week the teacher would have a story on the computer and the children had to listen to the story and answer questions as seat work. So when Nick was in the classroom and the other kids were listening to the story, with Nick answering the questions, he could see that the kids were hearing his voice, and no one was laughing.

This professional believed it was vitally important to use little subtle things to implement the child's voice into the classroom to avoid an over-reaction from anyone when the child did eventually hear the voice of the child with selective mutism. She also worked with the teacher to provide a lesson that desensitized the children and spoke to the children within the classroom about fears and how everyone has them. The lesson incorporated the sharing of fears not only from children, but from self-disclosure of the teacher and school social worker. Then they would explain what selective mutism was and about the child with SM from their classroom and the importance of not yelling and screaming and making a big deal about the speaking when it would happen. The lesson basically taught the children what they should and should not do once speech began for the child with selective mutism. One professional stated it like this, Um…For one kids we did, for Marie we talked about strategies that her peers could use during morning meeting in order to include her without her having to acknowledge verbally.

For some children where learning difficulties were impeding their academic achievement coupled with selective mutism, several of the professionals indicated the need for corrective feedback to be timed with relationship, comfort and safety of the student in mind. Many times anxiety is brought on by a feeling of embarrassment from not knowing how to complete a task, or from doing an assignment incorrectly. Two separate professionals indicated corrective feedback and timing as a need to be addressed with teachers when working with selectively mute students.

It's important to focus on what they did right, to acknowledge the positive steps and then not necessarily say that they made a mistake, you indicate what the next step would be.

Once they were comfortable and speaking, if even in a whisper, then I would instruct the

teacher that it is ok to provide corrective feedback.

The following was said with regard to a student who had qualified to be serviced through special

education and an individual education plan (IEP) due to low academic progress as well as little to

no social interaction as the impeding factors present in the school environment and issues being

compounded by selective mutism. This professional also saw a form of laddering being used in

servicing students with selective mutism in the special education department.

Pulling a child and working with them 1-1 in order to meet their academic needs is best

until they can feel comfortable enough to speak. Then gradually adding one to two more

students as they gain confidence is important. Generalizing to the larger classroom

setting or lunchroom, that is where things are tough and seem to be the biggest challenge

with these students. I would provide lunch bunch groups that met two times a week for

one of my students. She was given the task of handing out invitations to other kids from

her class that she wanted to join her for lunch in my office. Once they were done eating,

then we would play a game that she had chosen ahead of time to share with the other

girls. This gave her a way to network with the other students and choices of who to sit by

in the lunchroom, and who to play with at recess. The other girls ate it up. It proved to

be a great intervention strategy for this one student.

Many of the interventions or strategies used for working with decreasing symptoms of

mutism involved building in a sense of safety into the child with selective mutism's world

through the use of alternative means for communication. Being able to nod, or shake their heads

no in order to answer questions, or to use written response through checkmarks on a visual

schedule (for use with younger students who could not yet write) were among some of the

interventions seen as positive supports that built a sense of safety and comfort for students

struggling with the anxiety causing selective mutism. The following two quotes are examples of

two different strategies that enabled communication that allowed participation for students with

selective mutism in the classroom setting, but also supported assessing student's academic

progress toward grading. "I would provide white boards where they can do a written response or

a paper/pencil response. This seemed to be the most effective."

> The effective treatment strategy I use is cognitive behavior modification and stimulus
>
> baiting. I used games and goals that would vary depending on the age of the child.
>
> Subtly, I'm trying to get in his mind that, you know, you are a speaker. I then used
>
> stimulus baiting, where I start adding one more child at a time to form a small group with
>
> the child who is selectively mute. I start with the child he is secretly whispering to and I
>
> play games that he is motivated to win at. But I think that it is important to ask, you
>
> know…that multi-dimensional approach and how many of these kids have used outside
>
> services and therapy, medications, biofeedback training, etc.

A third professional thought that the use of a multi-dimensional approach was the way to

go for all of the students she had encountered in her many years of practice as a school social

worker. She stated, "One person was helpful from [mental health] agency. A person came out

and did a transition meeting with us and really talked about the strategies that worked with her

on their end, and then we incorporated and continued with those strategies they left us with."

School Mental Health Services

All of the professionals interviewed agreed that the school was the best place for the student to gain mental health intervention for selective mutism as that is the setting in which it is best to service children within the setting the behavior is occurring, unless the family was able to access a therapist who was willing to "team" with the school and provide consultation. Six of the eight of the school social workers interviewed agreed that although they worked directly with the child with selective mutism, they lacked the clinical knowledge base essential for therapy with this population. Several of the school based social workers school districts employed a co-located clinical worker who came into the school and worked individually with the child in therapy, as well as in advising the classroom teacher of techniques that were being worked on in therapy to be included within the classroom environment.

> We have a wonderful co-located therapist that comes in from [mental health] agency. She is extremely skilled in art therapy and building relationship with the kids. She has been the most effective in gaining verbal communication with students in a short amount of time. We love her because she has been so helpful to teachers in helping them to understand more about selective mutism and how it is affecting the child's life.

Another professional spoke of finding a psychologist in her area who was willing to go into the school system to work with the child where they were experiencing the issue of not speaking. She felt that it was important for the continuity of care and for the success of the student for the services to not only touch, but overlap with the school personnel involved with clients with selective mutism. It was felt that if school could not afford to employ a school social worker, or a co-located mental health practitioner, that a consultant be utilized as a part of the team of professionals to guide the work of school personnel working with selectively mute students.

I believe that services for these kids needs to take place right in the school. I work to find

an outside therapist who is willing to be involved with and consult with our school based

team. It only makes sense to service these kids in the setting they are experiencing the

anxiety you know. I have found two different psychologists who are great about working

with us in the schools, and this has made a huge difference.

One of the professionals felt like it was important for services within the school, along

with outside mental health services for students with selective mutism, remain with the same

trusted professional across time as extremely important for the success of students with the

disorder.

Continuity of case management is key in working with selectively mute kids along with

mental health services. Changing up who works with the child each year only serves to

send us back to square one. I work so hard to develop the trust that the child needs to be

able to speak and then the case manager has to change, and there you go, we're back

sometimes four years of work.

The Importance of Parent Involvement

Another theme that emerged from the data was the importance of a sense of family

connection with the school, however this was seen as a difficulty due to parents being seen as

part of the problem, or not seeing the problem as anything more than a personality conflict with

the teacher, and the teacher was to blame. This theme occurs because of the fact that it is

common for the selectively mute child to speak just fine in the home environment and essentially

a child presents as shy in other environments. Mutism does not show up until the child starts

school as noted in the literature review. It was noted that educators need to know family systems

to best serve the needs of their students. Children who were not receiving encouragement at

home to speak in uncomfortable situations, were shown to have longer term issues with expected

speaking at school. One professional expressed the following example of the need for

cooperation between home and school when dealing with selectively mute children.

> Whether a child receives services from an actual therapist, is actually up to the parents. It
>
> can be very frustrating to deal with a parent who doesn't think their child needs any help
>
> because they speak up just fine at home.

Several of the professionals stated that they were keenly aware that parent involvement

was in the best interest of the child with selective mutism because the parent was thought to also

be suffering from extreme shyness or having socially phobic characteristics that were noticeable.

None of the interviews realized information about a parent having an actual diagnosis, but it was

thought that a lot of parents had a propensity toward being socially phobic and this might be

playing a part in the mutism of the child as seen through multiple generations.

> Actually in all of the cases I saw, parents had some of the same issues as their kids. I had
>
> one parent, where I saw mom got very anxious at the meetings, and had a difficult time
>
> explaining why her daughter was how she was, so I think that created so much anxiety
>
> with mom, that she stopped coming to the meetings. I think relationship with parents is
>
> critical.

In most of the interviews completed, it was thought that one parent or the other were

struggling with issues of anxiety themselves. For this reason parent involvement was thought to

be an important aspect to consider when working with a child with selective mutism. One of the

professionals interviewed worked as a consultant to schools and families of children with

selective mutism and felt that teaching parents how to support their children and the use of a

team approach with the parent being the number one team player was of utmost importance.

> It has to be a team approach which would include, number one- the parent. I have a
>
> group for parents and they are so happy to be getting information on how to help their
>
> children. One parent once told me, 'I have been doing so many things wrong.' Parents
>
> know their child best, so they must be involved.

Staff Development

There was a belief among all of the professionals interviewed that selective mutism used

to be a disorder of speech. And thus children continue to be referred to the speech therapists

100% of the time for help. Speech clinicians are very aware of the fact that a debate is occurring

over selective mutism falling under the category of speech and language services, mental health

to service (due to an anxiety disorder or social phobia), or occasionally under the special

education category emotional behavioral disorder (EBD). The problem comes from the fact that

EBD services cannot step in unless the child is failing academically due to the mute behavior

getting in the way of academic learning or social progress. This is why it was discovered that

speech clinicians service the vast majority of students with selective mutism within the school

system. The second most commonly used professional students are serviced by are EBD teachers

within the schools, however this is rare as selective mutism has little to do with achievement in

school. This is supported in the literature as research shows that selective mutism has little to no

correlation with intelligence, sex, or race/ethnicity according to the DSM-5. The least commonly

used service is that of mental health services, mainly for reasons of not having adequately trained

professionals within the school system, or professionals willing to consult as a part of a team approach of services for children with selective mutism. The reason for this would require more research into the underlying cause.

> Many educators adapt lessons or classroom arrangement and materials in order to
> accommodate kids with selective mutism already, however there is an undeniable need
> for teachers and support services, and schools for that matter to gain an understanding to
> help these kids. Staff development with information that is helpful for the individual
> child and their unique set of circumstances is a necessity when a child with selective
> mutism is identified in a classroom.

> There is a clear need for clinical training among school based social workers that was

discovered through the semi-structured interviews. All but one of the professionals interviewed had not heard of the interventions the researcher had inquired about including**,** Dyadic regulatory system, cognitive-behavioral approach, modern psychoanalytic interventions, family systems approach, psychodynamic approach, multimodal approaches. One school social worker said with frustration and irritation in her voice the following:

> I find that I could use a clinical knowledge base to work more readily in the school
> system where these children are concerned. We are faced with a big problem when a
> child does not feel safe enough in their environment that they become silent. As it stands
> right now, we refer them out to therapists, and we never hear anything about how we can
> help the child where they are having the difficulty, and here we are struggling with the
> child in the school setting with what to do.

And another worker simply stated, I have not even heard of most of the interventions you

listed.

Discussion

The current research was conducted to investigate clinician's experiences and insights

with interventions to allow for the greatest success of students with selective mutism to

participate with success within the school environment. The researcher was interested in finding

the types of interventions and strategies that best serve this population of disability and what this

current research could contribute to the future services and knowledge base of mental health

professionals, especially within schools serving this special population. The primary purpose of

this paper was twofold. First, to examine the kinds of interventions/strategies that are being used

by professionals who are working with children with selective mutism and second, to better

understand how those treatments assist with self-regulation, and the development of a supportive

regulatory system for children with selective mutism.   Previous research indicated that treatment

should contain an educational component that empowers all adults in the environment of the

child with selective mutism (Cunningham, et al., 2004), thus the importance of this research is

revealed through professionals expressing the need for more education, and supports within

schools to aid in the success of children with selective mutism. This research study focused on

seven specific areas of inquiry underneath the two overarching questions. Those seven areas of

inquiry were: 1) the interventions/strategies that "clinicians" use with students who have

selective mutism 2) The interventions/strategies that have been found to be the most effective

with helping students overcome characteristics of selective mutism 3) The extent to which

clinicians have parental involvement when working with selectively mute students 4) The degree

to which clinicians aware of the history and background of parents with selective mutism and social phobia 5) of the means of educating parents used to create success for students within the general education setting 6) The means of educating school personnel that are used to help children with selective mutism succeed within the school environment? 7) The extent to which the school is involved in therapy involving children with selective mutism?

As outlined previously, there were six themes that emerged from the questions asked in this research. The research found a wide, yet similar array of thoughts regarding the work with the selectively mute child. The six major themes in this study revealed information beneficial for sharing with future workers serving this special population. Training in terms of identifying selective mutism as a mental health disorder is necessary as it was a theme in a majority of the interviews the speech clinician was the servicing agent and not a mental health practitioner even since the addition of the disorder to the DSM-5 in 2014. Research found that all practitioners believed that a mental health clinician would be best in serving someone from this population, yet speech and language services within the school systems was most commonly found to be providing service, with the second most common person servicing is the school social workers, and thirdly, special education services (EBD) along with "outside" intervention from a therapist.

Creating an environment for understanding behind the meaning of selective mutism as an emotional behavior was found to be of utmost importance. Creating an environment of safety to be experienced by the selectively mute child was pointed out as crucial to the future wellbeing of the selectively mute child. All eight of those interviewed spoke of different ways that exemplified the need for safety and comfort for this population of children. Providing a trusting adult that provides continuity of care along with exposure techniques throughout the span of education without speech, and continuing well beyond when speech first

starts to emerge was considered a part of this theme and extremely important. This is very much in line with the research found in the literature review that states, "Traditionally, selective mutism is minimized as simply being shy or as being treated as a negative behavior (opposition) that can be controlled by the child, thus the child receives punishment for such behavior. Because the behavior is not acknowledged accurately, the child is forced to attempt to regulate on his or her own without any assistance. The results can be seen in a child becoming even more silent to keep the anxiety contained while they are outside of the home (Moldan, 2005).

Intervention and teacher support was the third theme that emerged and consensus was clear among those interviewed that beyond parents, teachers are the most important part of the educational team. Psycho-education for teachers and providing resources and skills to create an environment of safety starting outside of the classroom in one-to-one meetings, then in small group situations, progressing to sharing of the child's voice within the classroom setting were seen as a ladder approach being used to encourage speech within the classroom environment. Helping teachers gain information and normalizing the feelings for all children around fear was found to be helpful to the education of both teachers and classrooms of children where a child with selective mutism was included. Education around reacting to the beginnings of feeling safe by use of the voice without surprise, shock or dismay was found to be an important factor in order to keep the child with selective mutism moving forward in their comfort and progress of speech in all settings. Teachers being able to educate the whole class about empathy and how everyone could include a child with selective mutism without pressure for verbal communication was stressed as an important finding. Classroom management and education was brought out as the bridge that could make or break the continuation of speech once started in the classroom and other learning environments.

It was unanimous among the professionals interviewed that the best place to access mental health support was within the school setting where the child spends most of their time. Furthermore, it was discussed and agreed upon through the majority of the professionals that school social workers and teachers lacked the clinical knowledge base essential for providing mental health service by researched methods to this special population. It was also felt that if school could not afford to employ a school social worker, or a co-located mental health practitioner, that a consultant be utilized as a part of the team of professionals to guide the work of school personnel working with selectively mute students.

Parent involvement was found to be of extreme importance yet difficult due to generational mental health concerns that continue to manifest themselves in younger generations. Although this research found that parental involvement proved to be beneficial, it was not always easy as much resistance was found either from parents being socially phobic and suffering from anxiety themselves, or through blaming teachers for personality conflicts with their children. Personality conflicts were thought to be occurring because their children were speaking at home and not within the school environment. Parents were reportedly of the belief that teachers were not providing the necessary comfort for their child to feel safe enough to speak at school. It was discovered in the literature review, that children whose parents and educators are involved in treatment make more progress developmentally and within programs designed to meet their needs (Brenton, 1994). Research findings suggest that where there is high importance placed on parental involvement for children with selective mutism. Research suggests the need for early intervention with program staff to be involved and encouraging parental involvement. These findings are important to the need for intervention with parents as key players in the development of children with selective mutism. Ultimately, it was found to be important to

share parental dis-ease with school systems supporting and working with selectively mute
children.

This research shows a clear need for increased levels of staff development with regard to
servicing this population within school. All but one of those interviewed had not heard of any of
the methods of practice most readily found through research. Seven of the professionals
expressed the need for more clinical knowledge to feel adequately trained to work in with
children with selective mutism. All those interviewed felt there was a need for schools to gain an
understanding of selective mutism to help children with their unique circumstances and
struggles.

Strengths/Limitations

Using an interview as method for gathering data, proved to be a strength. A semi-
structured interview allowed the researcher to have a set of predetermined questions, but also
allowed flexibility so that the interviewer could have the ability to go beyond the questions that
were asked and to clarify information given (Berg, 2009). For the purpose of this research, the
researcher was able to explore questions when needed which allowed for little constriction
within the interview questions. This allowed the participant and the researcher to have in-depth
conversation about the topic of selective mutism and the participants experience within the topic.

Data gathering through this semi-standard interview process allowed for flexibility that
could not have occurred through a mailed survey. Because accurate and complete information
was desired, the factors stated in Monette, Sullivan, & DeLong (2011) made using a semi-
structured interview an appealing qualitative research gathering technique. Interviewing also
made it possible to observe nonverbal communication that can prove to be valuable information
in research.

A possible limitation within the study is that the researcher had a previous history of working with children with selective mutism in both elementary and middle school settings. This bias may have influenced the types of questions asked on the interview schedule, how the questions were presented, and how the researcher developed themes within the findings. The researcher's faculty chair informed and approved the interview questions to decrease the amount of researcher bias.

There were few disadvantages within the interviewing process itself. Gathering enough professionals to draw conclusions from as a sample was the only major limitation. The results from the study cannot be generalized to the public due to the limited sample size. The data collected is rather suggestive than conclusive in nature (Monette et.al., 2011). Another limitation could exist due to interviewer bias. There also exists the possibility of bias due to the working knowledge of the interviewer and from having a previous relationship with one of the respondents. A third disadvantage was that due to most of the respondents living out of state, interviews needed to be done over the telephone which limited the "cryptic jottings" in field notes to two of the eight interviews.

Implications for Social Work Practice

Social work practice can directly be related to the current research because social workers could be providing the direct individual and group services needed to children with selective mutism. All of the professionals interviewed admit to the need for more education within the field in order to support children with selective mutism with the mental health services they so desperately need in order to not only be successful but comfortable and feeling safe within their school environment. Due to selective mutism being included within the DSM-5 as its own

category within anxiety disorders, it seems prudent that not only clinical social workers, but school social workers be at the forefront of intervention with this special population. Thus showing the need for education, support, and intervention strategies within the mental health field of study. The professionals interviewed in this study were in favor of learning all that they could about selective mutism and what types of intervention would work best with children experiencing selective mutism.

This research supports the need for policy and action that provides education for mental health services in the schools. It was reported in this study that more than half of the professional participants struggled to know the best way to help the selectively mute children they came across within the school environment. Furthermore, it is noted that due to the range of unique needs of individual children and responsiveness to intervention being less than a "cookie cutter approach", that school social workers be prepared and trained for the possibility of having to provide intervention to meet the mental health needs of students with selective mutism. Professionals reported in this study that students were not able to receive adequate mental health services at school to meet their needs due to having inadequate support people in place with the knowledge base essential for treating this special population.

Implications for Policy

More programs and training to educate mental health professionals working within the schools to help children with selective mutism could be helpful to teachers and support staff; even though most professionals generally had a sense of having to handle working with a child with selective mutism with extreme care, having a sense of agency to truly meet the child's needs was absent. The reasons for school not being able to provide the mental health services required is partially due to lack of clinical training, connection with outside mental health

providers with experience working with children with selective mutism and budget constraints that allows every school district to have a mental health professional on its payroll. Educators and mental health professionals need to continue to be advocates for policy to be enacted to provide school districts with the proper mental health services they so desperately need for a wide variety of student needs. This research supports the need for policy programs that provide the funding for mental health services to be available in the schools. It was reported by more than one professional that students were not able to receive adequate mental health services at school for reasons proving a lack of proper staff development, as well as a lack of proper trained mental health support within the schools.

Conclusion

The primary purpose of this paper was to examine the kinds of interventions/strategies that are being used by professionals who are working with children with selective mutism and how those treatments assist with self-regulation, and the development of a dyadic regulatory system that listens to the non-verbal cues of the selectively mute child. Although most of the professionals interviewed lacked the terminology of method, what they described as methods of treatment were allowing for children to feel comfortable within a dyadic regulatory system where non-verbal means were utilized in order to provide the safety and security to meet the students' needs and allow for progress and growth within the school environment. Treatment contained a psycho-educational component that empowered all adults in the environment of the child's life, from parents to classroom teachers. Creating an environment for understanding behind the meaning of selective mutism as a "real" emotional behavior concern was found to be of utmost importance as hypothesized prior to research.

This study has shown that there are various strategies and techniques utilized toward the progress in treatment for students with selective mutism. Treating selective mutism as a mental health disorder was the first concern addressed in intervention. The main focus was on the empowerment of students through educating teachers and other helping professionals within the schools with accurate information about selective mutism being a mental health disorder. The second intervention came in the form of creating an environment of safety and trust for students with selective mutism as progress was not seen without it. Professionals were said to go out of their way to provide classroom accommodations for children who have selective mutism to provide that end.

Development of support interventions and teacher support was clear among all of the professionals interviewed. Teachers having the proper psycho-education to understand the disorder allows for better relationship development. Relationship and trust being built through the use of non-verbal means was the foremost popular intervention in seeing progress from silence to verbal communication. Other interventions using laddering and desensitization allowed students to gradually feel safer to speak within the school environment. The use of little subtle things to implement the child's voice within the classroom and education of students within the classroom helped to avoid an over-reaction to the child's voice.   Having adequate staff available for individual work with students was shown to provide the 1-1 work needed to meet a child's social and academic needs. This process was found to be used to help generalize skills to the larger classroom setting. Cognitive Behavior Modification and stimulus baiting was shown to be effective with younger children. The use of a multi-dimensional approach using "outside" consultation professionals was proven to be helpful in assisting school professionals

with the education on intervention strategies that worked within a therapy setting as a child transitioned to the school environment.

All professionals interviewed agreed that the school was the best place for students to gain the mental health intervention needed to overcome selective mutism. Utilizing the "team" approach to not only provide consultation, but therapy services with students in the school as well as working with parents education related to the disorder aided in the development of relationship, care, and understanding for the wellbeing of students with selective mutism.

Mental health professionals were shown to have an important role in the schools to provide the extra support children with this disorder demand. It was found that there needs to be adequate mental health services within the schools readily available to make a difference early on in the treatment of children with selective mutism in order to have the best chance for creating a sense of normalcy and safety for this special population just as literature suggests.

There was a common theme which represented the importance of parental involvement for this population. It was discovered that two of those interviewed reported having a practice of consultation that informed and provided support for parents of children with selective mutism through realizing similarities in behavior between parent and student, and inviting them into team meetings, and encouraging consultation on psycho-education with parents.

Staff development has been seen as a need since the release of the DSM-5 as selective mutism now falls under the category of anxiety disorder and is seen as a diagnostic category within mental health. Schools are faced with a debate over who is charged with servicing this population as there continues to be a debate over selective mutism being a disorder of speech, or

a mental health concern. The study contributes to the learning and success rate and generalization of skills of not only school social workers, but other professionals working with children who have selective mutism within school setting as a mental health disorder.

Staff development was also shown as a need to develop an understanding of the disorder, to adapt lessons and classroom arrangements to aid the selectively mute child. Research showed that there is a clear need for clinical training among school based social workers, as none of the professionals were found to be aware of the correlation between parents mental health needs relating to that of anxiety or social phobia as it relates to raising a selectively mute child.

Educators and mental health professionals will need to advocate for more government funding for mental health services to be provided within schools. Furthermore, continuing education and training at higher levels of education for professionals will need to be put in place in order to inform practice. Presently, educators feel the biggest burden as they are often times left to their own devises when it comes to making accommodations for students with selective mutism.

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Appendix A Research Questions

Research question: What is the clinician's perspective on Interventions/Strategies Most Effective in Working with Selective Mutism and how can those interventions best be utilized to educate families and school personnel in supporting children with Selective Mutism within the school system?

1) What is your degree?
2) How long have you worked in the mental health field?
   a. Of that time how long have you worked with selectively mute children?
3) In the course of your work, approximately how many students have you worked with who have selective mutism?
4) What is your philosophy or theoretical approach you as a clinician use with students who have selective mutism?
   a. Are their specific methods or techniques that you use within that philosophy?
5) Of those that you have listed, what interventions/strategies have been most effective in helping students overcome characteristics of selective mutism?
   a. Why have they been effective? What makes them effective?
   b. Have you ever used Dyadic regulatory systems approach, Cognitive-behavioral approaches, Modern Psychoanalytic Interventions, or Family systems approach? Have you ever used them? What do you think about these interventions/strategies effectiveness?
6) What do you to support teachers who work with SM in their classrooms?
7) To what extent do you as a clinician have parental involvement when working with selectively mute students?
   a. Are you aware of the incidence of parents of SM children having a social phobia themselves?
   b. How do you think having this information would influence your practice with selectively mute children?
   c. What is your experience with parents utilizing interventions suggested? (If only seeing once a week or minimally)
   d. What are your thoughts on working with parents if time permitted? (If not working with parents)
8) To what extent do you as a clinician involve the school (teacher, support staff, etc.) in creating a treatment plan for students within the general education setting who have Selective mutism?
   a. How are teachers and support staff educated/utilized with treatment?
   b. What do you see is the most effective means of support in order to support children in generalizing skills being taught into other settings?
9) Do you have any recommendations for effective treatment strategies you use that may assist future therapist in their treatment of youth with selective mutism?
10) Is there anything that I have not asked that you would like to tell me about that may be helpful in my research?

Appendix B

A Qualitative Investigation of Clinical Perspectives with Regard to Practice with Selective Mutism

RESEARCH CONSENT FORM

Introduction:

You are invited to participate in a research study investigating clinical perspectives with regard to practice when working with selective mutes. This study is being conducted by: Melissa Scott, LSW, a graduate student at the School of Social Work, Catherine University/University of St. Thomas and supervised by Dr. Laurel N. Bidwell, M.S.W., Ph.D., LICSW. You were selected as a possible participant in this research because of you work in the field of mental health and work with selective mutes within the field. Please read this form and ask questions before you agree to participate in this study.

Background Information:

The purpose of this study is to gain insight on practices and knowledge in working with selectively mute children, families, and support staff within the school system to better understand the need for continuing education and cross systems approach in meeting the mental health needs of clients. Approximately 12 people are expected to participate in this research.

Procedures:

If you decide to participate in this study, you will be asked to sign and date this consent form. We will meet one time face-to-face or by telephone at your convenience. This meeting will take approximately one hour. I will be asking you to answer approximately 10 interview questions. There are no right or wrong answers. I am simply interested in hearing about your experiences.

Risks and Benefits of being in the study:

The study has minimal risks of loss of individual information. This risk is protected by de-identifying all data. In addition, all data will be kept in a password protected file on the researcher's personal computer. There is minimal risk that questions asked could illicit unforeseen emotional reaction. At any time, participants may object to answering any of the interview questions by telling the researcher. The participant may choose to terminate the interview at any time. Their decision to do so will not affect their current or future relations with the researcher or St. Catherine University.

There are no benefits to participating in this study although it will add value to evidence based best practices within the field of social work.

Confidentiality:

Any information obtained in connection with this research study will be kept confidential. In any written reports or publications, you will not be identifiable and only group data will be presented. No one in place of employment will know about your participation in this research study.

Transcriptionists will not have any access to your identifying information. I will be using quotes not identified by name however if there is a quote that you use quite often I cannot ensure anonymity that someone who is close to you may not be able to recognize this quote.

I will keep the printed research results in a locked file cabinet in my home office and only my advisor and I will have access to the records during the course of this project. Data analysis will be complete by May 31st, 2016. All transcripts and field notes and recordings will be destroyed along with any identifying information that can be linked back to you.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University in any way. If you decide to participate, you are free to drop out at any time without affecting these relationships. Should you decide to withdraw, data collected about you will still be used as evidence that an interview attempt had been made.

Contacts and questions:

If you have any questions, please feel free to contact me, Melissa (Scott) Raatz, 763-242-3261. If you have any additional questions or concerns about the study, the faculty advisor, Dr. Laurel Bidwell, (651) 962-5800 is also available to answer them. This report should be completed in May of 2016. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. I am aware that even after signing this form, I may withdraw from the study at any time.

_____

I consent to participate in the study. I am aware that the interview will be audio-taped and agree to its use.

_____

Signature of Participant   Date

_____

Signature of Researcher   Date