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What is selective mutism?

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WHAT IS SELECTIVE MUTISM?

A Project

Presented to the

Faculty of

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by

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ABSTRACT

Selective Mutism (SM) is a relatively rare childhood disorder that is closely related to social phobia. This is a condition when which children have the capability to speak, in fact they speak at home but they refuse to speak at school. Previous attempts to study the disorder have been hampered by the lack of a standard severity measure such as those existing for other psychiatric disorders.

This Investigation examines characteristics of Selective Mutism, its possible causes, the strong impact it creates in English learners students, and what teachers could do to help the students who suffer from this malady that year by year increase their presence in their classrooms.

ACKNOWLEDGMENTS

Everything we do in life must have something that inspires us and someone who motivates us. A little girl with big and beautiful dark brown eyes with long and curly hair was my motivation. She once came silently to my kindergarten classroom and stood silently for the rest of the school year. I did not know then that she was suffering from Selective Mutism. I started my research on this topic way before I had in mind to use this theme as my master's project. My brilliant professors from the Cal State University San Bernardino were my motivation. They not only taught me with their knowledge and expertise, but with their beautiful moral values of beauty, kindness and truth. I dedicate this humble project to Wendy Donis-Luna for being my inspiration, to all my professors at the University for being my motivation. To Doctors: Barbara Flores, Enrique Murillo, and Esteban Diaz for their kind guidance; to my friends Edelmira Jimenez, Celeste Carlos, Mary Loya, Gloria Torres, Rolando Quezada, and Kenny Solano for giving me their support; to my beloved husband Heriberto Garcia for all his patience and solicited help, to Tim Thelander for his invaluable help, and to all the teachers in the educational field, with the desire that

they may find an answer to this complex problem we face with selectively mute students.

DEDICATION

A mis amables maestros

De esta gran Universidad

Flores, Murillo, Whitaker, Torrez

Dias, Stine, Norton, Shea, Hernandez, Hall,

London, Pendlenton, Gonzalez, Schnorr,

Childress, Correa, and Negrete,

Quienes me enseñaron que bondad

Es aquello que se da

Con amor, con amistad,

Con sonrisas y

Con gozo.

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CHAPTER ONE

BACKGROUND

Introduction

Every year more teachers are facing this new problem: in their regular classrooms they have to teach selected mute students. This is a relatively new puzzle in our schools. Before, this condition was not known. Now, teachers have more cases of students with this ailment, and the problem is that many of them do not even know the name of this illness and consequently, they have no idea how to help them.

This study is important and relevant to education, in general, and bilingual education, in particular, because our bilingual students need to learn a new language, which is very different to the one they speak. If they do not produce any sound at all, not even in their maternal language, it is difficult for the teacher to teach them, even more, to assess them and verify if they are learning and how much learning is taking place.

The main hurdle arises when teachers have no idea of what is wrong with the student who does not emit any sound at all. Teachers have no knowledge of how to solve this situation that in all the cases, poses for them a very

serious dilemma. What makes the situation worst for the teachers is that local universities and colleges have not assigned studies to prepare and give docents the tools needed to help these particular students who suffer the malady of Selective Mutism.

Reasons for this Study: A Selectively Mute Student in my Classroom

Background

There she was, beautiful, slender, with her very long black and curly hair flowing down her back like a cascade. Her big beautiful dark eyes were showing anxiety. She was clinging to her pregnant mother, who was young, beautiful and was carrying a toddler in her arms. Since Wendy did not let go her mother's leg, the mother almost lost her balance. She was trying desperately to sit Wendy to the rug. The mother's eyes made contact with mine. They showed anxiety and the dilemma of what to do in an unfamiliar situation. As a response, my eyes expression was not of much help. I had so many children crying that I did not know at that moment what to think or what to do because I was confused too! There was so much noise in the room. It was the very first day of school for the majority of them, and many other children were crying in different ways,

some were silently, but others were screaming their lungs out.

I went to Wendy, the little girl. I held her by the arm first and then I hugged her. Rapidly, her mother walked fast to the door and left the room; she had tears in her eyes, and in her face was the expression of worry and sorrow.

With tears running down her cheeks, the little girl followed her mother with her sad eyes seeing her through the window until her figure disappeared. I noticed that something was wrong. Although the little girl was crying, she was not uttering a sound. She let go of my arms, and went to the floor to cry in a corner of the room. Her face was full of tears, but she was in complete silence. Even though there was much confusion in the room, and we were surrounded by noises, all of a sudden I felt an aura of eerie silence. Although the other children continued with their symphony of crying; nevertheless, there was silence all around. I know that there were only seconds, but for sure, there were very long ones. All of a sudden I was imbibed in the silence halo of this beautiful little girl with big and expressive brown eyes and a long a curly hair falling down to her back as a shinny cascade.

At that moment, I did not understand why she was not screaming as the rest of the children were. At that time, I recalled how normal it is for children to cry in their first day of kindergarten class because, for the majority, this was their first school experience. Nevertheless, I never had the experience to see a child that young, crying in such a pitiful way. For few seconds, the silent cry of this beautiful girl took me away from the chaos of my classroom; but the desperate crying of the other children brought me back to the reality of my noisy room.

Definitely, at that moment, seeing this little girl, made me understand that as a teacher, I was going to experience something new in my life. In a very abrupt manner, I knew that I had a problem upon my hands. Although at that time I had no idea what kind of problem, nevertheless, I knew that I was going to confront a huge one.

I had to leave the little girl crying in that corner of the room, and deal with nineteen other children. Some of them were crying, some of them were about to cry, and many of them were clinging to their mother's knees.

Little by little, the noisy uproar in the room settled down. I started singing with the guitar and the sweet faces of my new students, some with wet eyes and

noses, were quietly listening to my song. That was not Wendy's case. She still was silently crying in the corner of the room.

The following afternoon, the scene was almost the same. In the confusion of the first days, I did not pay too much attention to what was going on. By the end of the first week, I noticed that the little beautiful girl was not talking at all. I asked the mother, and she said that Wendy had just finished preschool and that she did not know why she was not talking in her preschool classroom either. The mother explained to me, that Wendy used to talk normally at home, and that she did not understand why she was not talking at school at all.

As the days passed by, I saw that Wendy was not uttering any sounds. She signaled with her hands or with body movements when she wanted something. When she wanted to go to the bathroom, she used to pull the dress of another girl and signaled her to the outside. The other girl used to come to me and tell me that Wendy needed to go to the bathroom. I never forced Wendy to talk, but surely, I did not know what to do.

I had a conference with both of Wendy's parents with no results. I had no clue of what was going on, and consequently, I did not know what strategies to implement

to help Wendy. I went for advice to the school counselors, but they could not help me. They said that they had no idea why this little girl was not talking at all. I went to the principal and vice-principal, and they, even though always willing to help us teachers, were not able to give me any advice. They never had an experience like this. I was confused and worried. I wanted to help Wendy, but I did not have the knowledge or the tools.

I felt like a big wall, which day by day was growing taller, and was standing between this little child and me. This is when I decided to educate myself about this condition and that is when I started this research. Although, at that time, I never knew this was going to be the theme of my Master's project, I started seeking an answer to this problem. Through the Internet, I learned that this malady had a name; it was called "Selective Mutism."

The months passed by, Wendy continued without speaking a word. I was not able to assess her. I did not even know if she could recognize the letters and sounds of the alphabet. One Friday afternoon, at the end of the class, before the beginning of the second trimester, I gave Wendy's mother a tape and a tape recorder and ask her

to tape Wendy's voice saying the letters and the sounds of the alphabet.

The mother was very kind to comply with my request. On the following Monday, in our classroom, the students were baffled to hear for the first time Wendy's voice. They thought that she was mute!

It was very hard for me as a teacher, to teach Wendy. I continued not knowing what to do. At that time, I could not find as much information as I am finding now. At that time I had no guidance; I had no path to follow. At my school site, none of the teachers had had a similar experience before.

One day, after the class was over, I asked the mother's permission to call Wendy at home. She told me: "I have an idea, let's pretend that you are my mother." I was hesitant; I did not agree with the idea. I thought that if Wendy discovered that I was not her grandmother, she was going to see that I, her teacher, was lying to her. Nevertheless, I called her at home. Wendy's mother answered the phone and I could hear her saying: "Wendy, te llama tu abuelita." (Wendy, your granny calls you). Wendy came to the phone, and with a very cheerful voice said: "hola abuelita." I was feeling nervous and uncomfortable, nevertheless, I said: "hola Wendy." Immediately, Wendy

recognized my voice and froze on the other side of the line. I could listen to what her mother was saying: "Wendy, habla, ella es tu abuelita." (Wendy talk, she is your granny). There was a silence. I was anxious. The mother took the phone and told me in Spanish: "I am sorry teacher; Wendy does not want to talk at all."

We hung up. I was very concerned and apprehensive. I thought that I had lost my last chance to help Wendy to talk. Somehow I felt troubled because I had lied to Wendy. I was not her granny. I felt that I let her down. Still I was by the phone; my mind was trying to think what to do. I did not want to give up. A soft little voice, which was growing second by second, was repeating inside of me: "There must be a way to help Wendy!" After two minutes, the secretary told me through the intercom: "Mrs. Briz-Garcia, you have a phone call on line 2." I ran to the phone, it was Wendy's mother. Her voice was full of enthusiasm. With so much joy, she said to me: "Maestra, Wendy quiere hablar con usted!" (Teacher, Wendy wants to talk with you!) I cannot describe my exhilaration. Nervously, I was waiting for Wendy to take the phone. While I was waiting, maybe one second; but to me, it was the longest second of my life. Wendy took the phone and said: "hola Maestra, te quiero mucho". (Hi teacher, I love

you very much.) I started crying. I could not believe that finally Wendy was talking to me. I could not consider that finally the big wall that stood between her and I was coming down. I could not believe that finally we could communicate verbally. I told her that I loved her very much.

Wendy invited me to go to her house. Since that night I did not have to go to the university, I went to her house. While I was driving towards her home, maybe no more than two miles, I was uneasy. What I was going to say? What I was going to do? Then, I arrived at Wendy's house. I parked the car still thinking about the outcome of that first visit. Nervously, I rang the doorbell. The mother opened the door and Wendy, my little student was there welcoming me with a big gorgeous smile.

She told me: "Teacher, I love you, I am so happy that you came to my house." There she was, speaking to me in English! Then she hugged me and brought me to the sofa. I brought her a book. I read it to her. She was in very high spirits. She showed me her skills in writing the numbers from one to 100 by memory. At that time, she was beginning to read. She gave me the name and the sounds of all the letters of the alphabet. I was delighted to see how much she knew.

After that first visit, many more followed. Every time I brought her books and presents. Although she was speaking to me at her home, at school she continued with her Mutism. Every day that I visited her, she asked me if I was going to go to her house the following day. I explained to her that if I had to go to the University, I could not go to visit with her. She understood well. At her home, she was very happy and talkative. I was very proud to see that academically, she was excelling at what she had to know at that time. Although Wendy never spoke in my class, I was very thrilled to see that she continued speaking to me over the phone, and was very verbal when I visited her at home. I was very cheerful because every night, Wendy called me at home. Not even that, but several months, after school ended and Wendy went to another grade and to another school, and had another teacher; she continued calling me over the phone at home.

Now Wendy is getting ready to go second grade. Since the beginning of this present school year, Wendy started talking to her teacher and with all her classmates. At her new school, no one knows that once she was a selectively mute student. Still, I go to her house and help her with her homework. Her parents cannot help her because they do

not speak English. I am very blissful to see that Wendy suffers from Selective Mutism no more!

Background of the Study

Selective Mutism is a problem that is increasing among the student's population. This study fits into the larger educational context because it is a very serious problem for teachers that have students in their classrooms with this condition and have no knowledge of how to name the problem, or how to face it. They have no clue how to help their selectively mute students.

This fits into the bilingual education context, because when bilingual students have this condition and do not speak at all in the classroom, they cannot produce the sounds of the new language they must learn. This project is important and worth doing, because it will give to teachers and parents who might face with this problem, an insight to what is Selective Mutism, and how to help the students who suffer this condition, to achieve success at school.

The pertinent background factors that the readers need to know about this area of study is that:

- Selective Mutism is a social phobia; consequently, it is an illness.

- Selectively mute students are not stubborn students who want to defy authority by not talking.
- Selectively mute students are not mute; therefore, they have no physical impediment.

Statement of the Problem

The specific research questions that this study tries to answer in this project are: "What is Selective Mutism and what can teachers do to help Selectively Mute students?"

Purpose of this Study

The intention of this project is to let other people, especially teachers and parents know what Selective Mutism is; to investigate the academic implications and the effects of this illness in selectively mute students; and to show how detrimental it is for bilingual students and what can be done to improve their condition.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

The National Institute of Mental Health, NIMH, which is a component of the National Institutes of Health of the U.S. Department of Health and Human Services, in its publication No. 02-3879, printed for the first time in 1994, explains that Anxiety disorders are very serious mental illnesses. About 19 million American adults are affected with conditions that have to be with fear and anxiety. Of course that sometimes people experience brief anxiety or distress, maybe because of a business presentation, a test at the University or a date. These conditions are not related with anxiety disorders, because as soon the test is over, or the presentation is done, or the date has been accomplished, the fear and distress disappear. On the other hand, the characteristics of anxiety disorders are persistent and unrelenting. If a person with these conditions is not treated on time, the symptoms will grow worse.

One of the reason why the conditions of Social Phobias, Post-traumatic Disorders and Obsessive Compulsive Disorders or Tourette Syndrome are briefly described in this project along with Selective Mutism which is the

central theme of this study; is because the National Institute of Mental Health wrote: "Each anxiety disorder has its own distinct features, but they are all bound together by the common theme of excessive, irrational fear and dread." In many cases, a selectively mute person may have associated disorders like the ones mentioned above. This is why these concepts are included in this project, because they can give more insight to the reader about this condition of Selective Mutism.

In general, Social Phobias are also called anxiety disorders because the people with this malady, has an overwhelming anxiety and excessive self-consciousness in their ordinary social situations. They feel that they are observed and judged by others, and that they are the center of attention. They feel that they are being observed in whatever they do, consequently, they feel humiliated if they feel that it is wrong. If this condition is not treated on time, it can seriously interfere with simple everyday simple actions like eating, drinking, or writing in front of other people. Sometimes, people who suffer this condition can always feel uneasy when they are around people. Social phobia can break friendships and keep the sufferers of this condition away from friends and relatives. Social phobia sufferers may be

painfully embarrassed by the symptoms of blushing, profuse sweating, trembling, nausea and difficulty talking which are the body expressions of their extreme anxiety. These people feel as all eyes are focused on them, and may be afraid of being with people other than their family. As one of the patients put it in his own words:

> In any social situation, I felt fear, I would be anxious before I even left the house, and it would escalate as I got closer to a college class, a party, or whatever, I would feel sick to the stomach-it almost felt like if I had the flu. My heart would pound, my palms would get sweaty, and I would get this feeling of being removed from myself and from everybody else.

Social Phobia usually begins either in childhood or early adolescence. Men and women alike are equally to develop it. This condition affects about 5.3 million adult Americans. This condition also may develop when people try to "self-medicate" their social phobia by drinking or using drugs. When psychotherapy and medications are used wisely, Social phobia can be treated successfully.

People who suffer this condition can see their normal lives severely disturbed. Social phobia can be intrusive with school, work or social relationships. The dread of a feared event can begin weeks in advance and be incapacitating. What causes it? The cause is a combination of two things, genetics and environment.

This condition can be very disabling. These people are often "loners" but really, they do not want to be. Children, who suffer this, have poor social skills. They are very lonely; they have no or few friends. Usually, these children are not involved in any after school programs. Some of them express they dislike of attending school, and some of them refuse to go to school at all. Since these children with social phobia rarely have extreme conditions and they do not present behavioral problems at school, it is hard for parents and teachers to find out that they are suffering from an Anxiety Disorder. Usually teachers think these children are very nice,

Genetics: Anxiety disorders are inherited. Many children will have one or two parents with anxiety disorder, but not necessarily Social Phobia. Many people think that his inheritance is in par expressed through something called Behavioral Inhibition.

Behavioral inhibition is a propensity to react negatively to new situations or things. Some infants and children will be very exultant and curious about new people and things. However, roughly 15 % of children will be very introverted, withdrawn, and irritable when they are in a new situation or with new people or things.

Other children are just apprehensive in general. Often these children are irritable as infants, shy and fearful as toddlers, and cautious, quiet and reclusive at school age. Children, who exhibit consistently this behavior, have much more likely biological parents with anxiety disorders. They are more likely to develop social phobia later in childhood or in adolescence. For example, if a child is not frightened and does not avoid social situations, there is only a 4-5% change that he/she will get social phobia as teenager. However if a child is fearful and avoid social situations when he/she is little, there will be about 20-25% chances that he/she will have social phobia as teenager. If this tendency towards being fearful and socially avoidant runs in families, it can lead to social phobias.

Environment: by this it is preordained everything else but genetics. Some of the environmental causes of Social Phobia are: a Speech or language problem, a disfiguring physical illness, abuse, neglect, being raise by very nervous people and having certain ill at ease experiences like vomiting during show and tell, having diarrhea in class, tripping on stage and falling on someone doing a performance in school. Etc.

In most cases it is a combination of both genetics and environment. It takes a big genetic weight (both parents have multiple anxiety disorders) to cause Social Phobia in the absence of any environmental problem. Similarly, it takes a huge environmental cause (massive abuse and neglect) to cause an anxiety disorder when there is no family history of nervousness.

Selective Mutism (SM) is defined as "An unrelenting failure to speak in specific social situation where speaking is expected, despite speaking in other situations". (American Psychiatric Association, 1994) The diagnostic criteria also state that the disturbance must interfere with education achievement or social communication and last for more than one month.

Post-traumatic stress disorder is a debilitating condition that can widen following a terrifying event. Often, people with post-traumatic stress disorder have persistent frightening thoughts, reminiscences of their ordeal and feel emotionally unfeeling, especially with people they once were closer to.

After the soldiers came back from the Second World War, they were the first ones to make people aware of a condition called Post-traumatic stress disorder. In reality, this condition can result from any number of

shocking incidents. These may include aggressive attacks such as an ambush, rape or torment; being kidnapped or held captive; child abuse; grave accidents such as car or train wrecks; natural disasters such floods or earthquakes. If people had lived the experience of almost loosing their lives, or had seen someone they love almost loose their lives, then, most likely the occurrence that triggers post-traumatic stress will surface. Also, it could be something witnessed, such as a massive death and destruction after a building is bombed or a plane gone down.

A fact that makes this condition worst is that people, who have had these dreadful experiences, relive them, because they have nightmares and have disturbing memories during the day. They also experience insomnia, feel detached or without sensation, or be easily shocked. They may lose concentration in things they used to enjoy and have trouble feeling demonstrative. They may undergo feelings of irritability, more hostile than before, or even vicious. Since the things that remind them of the ordeal may be very painful, some people try to avoid places that bring back these reminiscences. They feel very nervous when the anniversary of the event that created

this condition is closer. The following testimony is an example of this condition:

> I was raped when I was 25 years old. For a long time, I spoke about the rape as though it was something that happened to someone else. I was very aware that it had happened to me, but there was no feeling.

Obsessive Compulsive Disorder or OCD, involves concerned thoughts or rituals people who put up with these feel they cannot control. They are under pressure by persistent, annoying thoughts or images, or by an imperative require fitting into place definite rituals.

This people may be fixated with germs or dirt, so they wash their hand over and over. They may be filled with doubt and feel the need to verifying things repeatedly. They may have frequent thoughts of hostility and fear that they will damage people close to them. They may spend long periods touching things over and over, or counting them; they may be pro-occupied by order of symmetry (like those persons that go to someone house and can not resist to straight up a picture on the wall that might be a little crooked). They may have unrelenting thoughts of performing sexual acts that are disgusting for them; or they may be disturbed by thoughts that are against their religious faith.

The disconcerting thoughts or images are called obsessions, and the rituals that are performed to try to preclude are called compulsions. There is no pleasure in haulage out the rituals they are drawn to, only fleeting relief from the anxiety that grows when they do not perform them.

For instance, some people feel that their hands are dirty and they wash and wash their hands up to above the elbows. Since during wintertime, the air is very dry; the skin of these people opens and bleeds. Other people show sings of this condition by cleaning in excess, to the point that they even clean even the inside of the toilet tank.

Many healthy people can identify with some of the symptoms of obsessive compulsory OCD, such as checking the stove several times before leaving the house. Nevertheless, for people with some of the symptoms of OCD, consume an hour a day performing their excessive cleaning rituals, are very upsetting, and interfere with their daily activities, because most of the time, the people who suffer from this condition, are usually late for appointments, or even late for simple gatherings like going to dinner or going to church.

Most adults that are anguishing from this condition know that what they are doing have no sense at all, and they feel bad about it, but, because it is a compulsory situation, they can not stop the abnormal behavior that many times makes them feel ashamed. Some people, especially children who suffer from this woe, may not realize that their behavior is out of the ordinary, and that they make other people uncomfortable with it.

Here is the testimony of a patient with this illness:

> "I couldn't do anything without rituals. They invaded every aspect of my life. Counting really bogged me down. I would wash my hair three times as opposed to once, because three was a good luck number and one wasn't. It took me longer to read because I'd count the lines in a paragraph. When I set my alarm at night, I had to set it to a number that wouldn't add up to a "bad" number.
>
> Obsessive Compulsory Disorder afflicts about 3.3 million adults Americans. It hits men and women in the region of equal numbers and usually first appears in childhood, adolescence, or early adulthood. One-third of adults with OCD stated having their first compulsory symptoms as children.

Like heart disease, diabetes, and other illnesses of this kind, these brain disorders are complex and probably result from a combination of genetic, behavioral, developmental, and other factors.

A number of parts of the brain are key actors in a vastly dynamic interaction that gives rise to apprehension

and nervousness. Using brain imaging technologies and neurochemical techniques, scientists are finding that a network of interacting structures is responsible for these emotions. Much research centers in the amygdala, and almond-shaped configuration deep within the brain. The amygdala is believed to serve as a communication focal point between the parts of the brain that process incoming sensory signals and the parts that take to mean them. It can signal that a peril is near by, and triggers a fear response or anxiety. It appears that poignant memories stores in the central part of the amygdala may play a role in disorders involving very divergent uncertainties, like phobias; while different parts may be involved in other forms of disquiet.

Other erudite focus on the hippocampus, another brain structure that is responsible for processing intimidating or harrowing stimuli. The hippocampus plays a key role in the brain by helping program information into reminiscences. Studies have shown that the hippocampus appears to be smaller in people who have undergone severe stress because of child abuse or military combat. This reduced size could help explain why individuals with some cases of social phobias may have flashbacks, deficits in

explicit memory, and disjointed memory for details of the disturbing event.

Selective Mutism is an acquired disorder of interpersonal communication in which a child does not speak in one or more environments where communication typically occurs. These children most often refuse to speak in school and to adults outside the home. Some children with SM sill not speak to any child; others will use speech with only a few other children. Parents report normal speech within the home with at least one parent and sometimes with siblings. The Araneum Nostrum WebRing (2002) referring to Selective Mutism emphasizes, that: "The disturbance must interfere with education, occupation or social communication."

Theoretical Framework

Medically speaking, Kristensen, (2002) H. from European Child & adolescent Psychiatry says that Selective Mutism (SM) in children is frequently associated with language disorder/delay suggesting that neurobiological factors may be involved in the development of SM. Motor Co-ordination problems, reduced optimality pre-and perinatally and minor physical anomalies represent other markers for neurodevelopmental disorder/delay.

Other authors say that Selective Mutism is an infrequent phenomenon, often first identified in the school setting (Gidan, 1997). Approximately 1 percent of children suffer from a form of childhood social anxiety, which prevents them from talking in public. Previously known as Elective Mutism, doctors changed the name as it implied an international stubbornness on the part of the child. (Schultz, 1999)

It is the persistent refusal to speak in specific situations by children who have already demonstrated an ability to speak (Hoffman, 1996). This is an acquired disorder of interpersonal communication in which a child does not speak in one or more environments where communication typically occurs. These children most often refuse to speak in school and to adults outside the home. Some children with SM will not speak to any child; others will use speech with only a few other children. Parents report normal speech within the home with at least one parent and sometimes with siblings (Stein 2002)

Many researchers have made a distinction between transient and persistent SM and have suggested that persistent SM could be a more severe condition (Wilkins, 1985, Tancer and Kelin, 1991). Parents of older children (Who are likely to have had a longer length or illness)

reported higher rates of interference and distress associated with the disorder than those of younger children (ages 3-5).

Early Studies

A German Physician, Kussmaul, first reported selective Mutism in 1887. He described physical normal children who developed Mutism in certain situations. He called the condition "Aphasia Voluntals," meaning voluntary Mutism. Later and English physician, Trammer, (1934), described several similar cases and coined the term "Elective Mutism." He suggested that this term be used to classify children who spoke only to certain people. (e.g. Family members and closes friends), but not to others. The word "elective" is suggestive of a preference not to speak; the term therefore implies a deliberate decision not to speak. The term was changed in 1994 as Selective Mutism, to imply a less oppositional or willful component.

Children have been incorrectly labeled autistic, mentally handicapped and defiant; but in reality they are suffering from a severe phobia that causes them to be withdrawn and silent. (Sharon L. Long, My Silent Child, 2001).

Recent Studies

Children who fail to speak in situations where speech is expected or necessary, to the extent that their reluctance or failure interferes with school and making friends, may be suffering from Selective Mutism, though to be a severe form of Social Anxiety Disorder. Onset of Selective Mutism is usually before five years of age, but it often comes to a head when the child enters school. The average of diagnosis is between 4-8 years old, but these children probably exhibited "extreme shyness" at a much early age. For Selective Mutism to be diagnosed the behavior must persist for at least one month. These children can be very talkative, even boisterous when they are at home, or in a place where they feel comfortable.

Sharon L. Longo, in an excerpt of her document "*My Silent Child*" describes:

> I have a five-year old boy, my third child, and he has a cherub's face with a hint of mischief in his beautiful green eyes. He can dance around to silly music and entertain us with his antics. He has no problem telling his brother lo leave him alone while he is playing. He has no qualms about teasing his sister while she does her homework. The only difference between Brian and most other children his age is that while he is at school, he is mute. He will not raise his hand to answer a question or to ask to use the bathroom. When the children count off in gym class, Brian holds up his fingers, leaving a momentary sound lapse until the child after him calls out the next number. Brian is not mentally

> handicapped or autistic. He is not deaf or speech impaired. Brian suffers from Selective Mutism, a debilitating childhood anxiety disorder whereby a child who has the capacity to speak and understand the spoken word in the comfort of his home is unable to speak in select social settings like school or church.

When children with Social Phobia go to school, the problem is more evident. They are more likely to be embarrassed about what they say a school. Often they are embarrassed about how they look, what clothes they have on, and how their hairdo is. If the doctor prescribes them to wear glasses, it is very difficult for the parent and for the teachers to have them wear them, because they believe that everyone is going to laugh at them.

They may be afraid of looking or doing something that might be seen as stupid. This conducts to a person doing very little, so as to avoid making mistakes. One of the most common problems is speaking. Some children, when they say something wrong, get so embarrassed that they do not speak any more during the whole class; once they are out of school, they speak freely with their friends and relatives. Children with social phobia have a circle of people who they will speak with. Sometimes it is as small as the immediate family members and friends. When children have this inability to talk in social settings, it is

called Selective Mutism, which is a type of social phobia, which is more severe.

The New York University Child Study Center, in their Publication About Our Kids Org. Their Selection of "*About Selective Mutism, Profiles of Silence*" (2002) stated:

> Those who have worked with selectively mute children have encountered wide variations in their social actions. Some children enjoy contact with others and will play easily, but remain silent. Some have a close friend who often speaks for them by interpreting gestures. Others find all aspects of social situations uncomfortable and do not participate al all. Whatever form for the condition takes, it can persist. There are children in the 2nd, 3rd, and 4th grades who have never spoken in school. There are students in high school who have not uttered any or no more tan a few words in a school setting. As you can imagine, the condition can have dramatically negative effects on social functioning.

It is very important to make sure that selective Mutism is not misdiagnosed. In some studies, almost half of the people who seemed to have most of the symptoms and therefore thought to have Selective Mutism were found that they did not have this condition at all.

CHAPTER THREE

GUIDING QUESTIONS FOR TEACHERS AND PARENTS

Since Selective Mutism is a condition not widely known by parents and teachers at large, and, although they can see the symptoms of Selective Mutism in Selective Mute Students, they do not know how to interpret them. It would be beneficial for them to have an idea of the questions that may arise once they have this problem in their hands; and it would be doubly beneficial to have the possible answers to the following questions. In this way, maybe they could learn a little bit more about this condition since year-by-year, more and more selectively mute students appear in our classrooms. The following questions were considered by the Mutism Foundation, Inc. (1993)

- What is the current Status of Research on Selective Mutism?

  At the present time, many researchers are doing investigation, diagnosis, assessment, and treatment of people, mainly children, who suffer from Selective Mutism. The main focus of these studies, are the specific factors that contribute to the development of this illness, as well as the development of an

effective assessment and treatment technologies for children experiencing this problem. Anxiety, shyness, and social-phobia are being considered as probably contributing factors. The Social Anxiety Web site (2002) declares: "Currently, there is little information on how to plan an individualized treatment program for Selectively Mute children."

- How do you know that your student suffers from Selective Mutism?

  a) The selectively mute student does not speak at all, not even when it is an imperative need to do so.

  b) If the case is a kindergarten student, when the parent brings h/her to the school, h/she, clings to the mother's/father's legs and cry in silence.

  c) The selectively mute student does not participate in reading, writing or repeating chants in the classroom.

  d) Although their facial expressions may reveal that they are happy; they may clap, march, even dance, but they do not pronounce any word, nor emit any guttural sound.

e) Sometimes, children will participate, sometimes, the same children will not.

f) Some children with this condition do not speak at all during the whole school year. They refuse to speak even when they are playing in the playground, and when they are with their parents when they come to school to pick them up.

g) Sometimes, as soon the parent and child cross the school gate, the Selectively Mute child starts telling the parent what happened during h/her day at school.

h) The child expresses h/her needs with body movements.

i) The selectively child usually pull the clothes of another girl or boy to let h/her know that h/she wants to go to the bathroom.

j) Usually these children do not smile with frequency.

- Is Selective Mutism limited to children?

No, some children do experience Selective Mutism for short periods of time, some for a little longer, but the condition disappear; while other experience this problem for many years; even they might reach adulthood, and still have the problem. Based upon

some literature and responses to the Selective Mutism Foundation, this can be a persistent disorder, which can become intractable over time. Some adults report they are still struggling with symptoms of this condition.

- How many people have Selective Mutism?

  Published literature suggest that Selective Mutism is rare, found in less than 1 percent of child guidance, clinical, and school social casework referrals.

  However, based on the overwhelming responses to the Selective Mutism Foundation, there is the suspicion that it is far more prevalent that originally assumed. Some publications suggest a slightly higher percentage of females experiencing Selective Mutism than males. However, due to unreported, undiagnosed and misdiagnosed cases, the ratio is unknown.

- What is the diagnostic and statistical manual of mental disorders (DSM IV)?

  The Diagnostic and Statistical Manual of Mental Disorders is the most widely used diagnostic reference book utilized by mental health professionals in United States. Due to the lack of

research on Selective Mutism, the diagnostic criteria had to be assertive by examining existing publications. The available publications present various theories, many of which describe children experiencing Selective Mutism to be controlling, manipulative, oppositional, and angry. Due to this, as we perceive, there has been a mischaracterization of Selectively Mute children, Selective Mutism association with anxiety has been neglected, and parents have been frequently blamed for causing Selective Mutism in their children. Trough mutual efforts and current research, changes have been made in the Diagnostic and Statistical manual of Mental Disorders.

- Does individual experiencing Selective Mutism have associated behaviors?

It is common for an anxiety disorder to be accompanied by anther anxiety disorder or another illness. Often adults, who experience any other social phobia, also may experience intense sadness and despair, eating disorders, or alcohol or drug abuse.

In children with Selective Mutism, associated behavior may include no eye contact, no facial

expression, immobility, or nervous fidgeting when confronted with general expectations in social situations. These symptoms do not indicate willfulness, but rather an attempt to control rising anxiety. Some may suffer from Obsessive-Compulsive Disorder or Tourette syndrome symptoms and a variety of phobias as well.

- What are the first symptoms of Selective Mutism?

  Children suffering from Selective Mutism may present the following behavioral characteristics:

  a) Stand motionless and expressionless,
  b) Turn h/her head opposite to the person who is talking.
  c) Chew or twirl hair,
  d) Nervously chew the collar of h/her t-shirt,
  e) Suck h/her thumb,
  f) Avoid eye contact or withdraw into a corner.
  g) Become anxious before entering an uncomfortable situation,
  h) Common symptoms of anxiety before social events include: stomach aches, headaches, and other physical ailments.

i) Will often display additional signs of severe anxiety, separation anxiety, frequent tantrums and crying moodiness,

j) Inflexibility, sleep problems and extreme shyness. These symptoms can show up as early as infancy.

- Is Selective Mutism caused by abuse?

There is not much research about this concept. Due to the misdiagnosed of the symptoms, some parents have been suspected or accused of child abuse. Sexual abuse has been suspected as well. The Selective Mutism Foundation emphasizes the vital need to clarify these unjust assumptions. The suspicion or accusation of parental child abuse is devastating and has caused tremendous grief and prevented many families from seeking help for their children. There is always a possibility that some children who have been abused do not speak. However, the abuse may not be specific to immediate family members, but could occur from any adult or even other children. It is best to contact the appropriate agencies if there is a definite indication of abuse.

- What causes Selective Mutism?

The cause has not yet been established. Current systematic research studies are under investigation for the possibility of a genetic influence or vulnerability for Selective Mutism. Doctor Bruce Black M.D (2000) explains:

At the present time, we cannot say with certainty what causes selective Mutism. There may be different causes for different individuals. Our research to date indicates that most children with this disorder are very shy and anxious when interacting with unfamiliar persons or in any situation where they feel that they are the center of attention or are being observed or evaluated. As they become more accustomed to and comfortable in a particular social situation, they are more likely to talk. It seems likely that this extremely shyness or self consciousness ("or social anxiety" as it is referred to by psychiatrists) is the central cause of the disorder. In fact, it seems likely that in many cases selective Mutism is no more than an extreme shyness or an early childhood form of "public speaking anxiety." Many of the children we have studied have parents or siblings who have suffered from selective Mutism or from extreme shyness. This

observation, as well as what we know about the hereditary bases of extreme shyness, suggest that a vulnerability or tendency to develop the disorder is passed on genetically, just as a tendency to develop diabetes or heart disease may be passed on.

- How is Selective Mutism diagnosed?

The crucial diagnostic element is that the child has the ability to booth comprehend spoken language and to speak, but fails to do in selected settings. These children will display reasonably appropriate verbal and interactive skills at home in the presence of a few individuals with whom they feel at ease. The term Selective Mutism should do prepare the individuals who demonstrate selectivity with whom they speak from individuals who speak to no one. A population, which should be excluded, is immigrants who speak another language, have no history of the disorder, and experience Selected Mutism for a short period of time. In these cases, the Mutism is usually transient.

- Is there a relationship between Selective Mutism and Autism?

No. Selective Mutism is sometimes erroneously mistaken for Autism. The striking differences between

the two are the Autistic individuals have limited language ability, while individuals experiencing Selective Mutism are capable of speaking and normally do so in a comfortable situation.

CHAPTER FOUR

VIABLE STRATEGIES

That Can be Used to Help Selectively Mute Students to Speak

When a teacher in the classroom or a parent at home has a child who presents the characteristics of a selectively mute individual, and they have no knowledge of this condition, they will not have the means to treat it. It will be very difficult for them to help the child to overcome it. The following questions may give the reader an insight as to when Selective Mutism should be treated, and if these students have the need of special education.

When should Selective Mutism be Treated?

There are two main factors in determining when treatment is necessary: age and severity, if the Mutism persists for more than two months, or another dominant language is not interfering, and if there are no verbal responses at all, treatment should begin immediately. For the child who exhibits mild symptoms, such as responding in a soft voice, and who interacts with others, treatment may not be necessary unless the symptoms continue for many months.

It is sometimes complicated to know if or when to intervene, as there are variant degrees of the disorder.

Many children progress over time without treatment, while others, the disorder becomes adamant. For those experiencing rigorous forms of Selective Mutism, immediate intervention is imperative because these symptoms can increase and intensify. Generally speaking, a younger child has a good chance of recovering, if treated, because of the shorter interval of time where non-verbalization has occurred in school or in other major settings.

Behavioral management based on the treatment of phobias has proven to be successful. Techniques should be steady, and should include desensitizing the child by providing short-term goals, positive reinforcement, and rewards to motivate the child to speak. Force, including chastisement, enticement, or penalties are detrimental. One word responses should be elicited at first, with continuing request for more. After extensive treatment, some have been able to speak instinctively in some, if not all, social situations. Anti-depressant drugs, known to be effective in treating adults with anxiety and/or social phobia have been effective for many children, by and large in conjunction with behavioral treatment. Several articles can be found in major libraries, which provide behavioral strategies.

The effective treatment of Selective Mutism consists of steps to address three basic problems:

- The child's high level of anxiety in social situations.
- The limited experience the child has had in speaking with people other than family members.
- The high level of support that is present for nonverbal communication.
- Supportive or exploratory psychotherapy has not proven very successful though these approaches may be important in building great confidence and a more relaxed orientation in life. How can teachers assist a student who is experiencing Selective Mutism?

Teachers play an integral part in helping students who are experiencing Selective Mutism. By understanding that the symptoms are not intentional, teachers may reduce frustration and anger. Consistent behavioral strategies should and can be easily implemented in the classroom. Strategies should focus on encouraging, not forcing, the child to speak. Praise and rewards for speaking, and completion of classroom task (e.g. Monitor), will all

contribute to lowering anxiety, while helping the child to feel included, positive and independent.

- Establish what is meant by Selective Mutism
- To understand that this kind of students do not have language difficulty.
- Outside the contexts in which they choose to be mute they are able and willing to express themselves and they do so.
- In the contexts that they are mute, they make no sound whatsoever; or if they do, the sounds they utter are not speech.
- Take time to understand the rule system the child has with respect to their Mutism and speech. For instance if the child do not speak at school, at what point will they s/he speak?
- Does h/she talk as soon they leave school?
- Does s/he speak as soon they see their mother?
- Their rule system could be more complex of what it is expected.
- Teachers must have a reasonable understanding if they want to intervene in these cases.
- They must be guided by patience, love and care.

- Once teachers discover and establish the rules, they will be able to predict when the students will speak and when they sill be mute.
- Find a friend that s/he talks outside school.

How can Educational Evaluators Asses the Skills of a Child Experiencing Selective Mutism?

Professionals will need to modify their typical assessment strategies when working with these children. As these children do not verbalize, evaluation scores do not reflect their true academic levels, IQ's or potential. In order to avoid placing these children into appropriate education settings, evaluators need to be particularly cautious. An Effort should be made to evaluate the child at home with the parent present. The child can be asked to read into a tape recorder at home. Some skills, speech and language samples may be obtained and assessed over the phone as many children experiencing Selective Mutism will verbally respond. Testing material, which is used for the deaf population, is advantageous as well. One of the goals is to promote the development of appropriate testing material for those children who may have additional disabilities.

Do Children Experiencing Selective Mutism have Special Education Needs?

Selective Mutism is no associated with learning or other impairments; therefore special education programs should be cautiously considered. There are no especial education programs in public schools available for these children (outside of those that level the Selectively Mute child as emotionally disturbed). Therefore, individual programs would need to be designed. Most programs can be implemented within the regular educational environments; others may require coordination between regular and Special Education school staff, depending on the skill level and resources available within the school district.

CHAPTER FIVE

SUMMARY

The motivation for this project was to have a clearer picture of what Selective Mutism is and to explore ways that other parents, teachers and administrators have done about this problem once they have the need to do something about it. In addition, I wanted to find medical opinions to alleviate this illness, and above all, to search for methods and strategies so I can have tools to help other "Wendy's" that may cross the path of my life as a teacher. All of these concerns have only one goal: Help our students who suffer from this condition. I hope that this humble work may help other teachers that like me did not known where to go, what to do, or to whom go for answers.

It has been very beneficial to me finding out about this information. I can see that more and more, as other works of investigation are surfacing. I believe this is because Selective Mutism is appearing more and more in our classrooms.

Conclusions

Based on the experience I had with Wendy in my classroom, and the literature review, these are the conclusions that I have reached:

- It is very important to understand that Selective Mutism is an illness; therefore, it is very vital to remember that the child who is Selectively Mute is not stubborn, is not trying to defy our authority, and h/she does not speak to make us mad. Consequently, we must always treat the students who suffer this malady, with respect, love, acceptance and care. We, teachers, must never force them to speak, menace them, or get angry at them because their lack of speech
- We must try to educate ourselves and know what this condition is if we want to help our students. Here, the factors of persistence, determination, and compassion are very important. Persistence, because we should not let the obstacles we might encounter to deter us to find what this condition is and what we can do to help our Selectively Mute Students. Determination, the other important factor, because once we know that we have a problem, we should not cease, until we have exhausted all the means to solve it. Compassion, because if everything else fails, with compassion we can

talk the language of love, care and concern. These students are very sensitive to the way teachers treat them. (Here, I remember what Wendy told me when I went to her house: "Teacher, I love you, I am very glad that you came to my home.")

- The third conclusion that I believe is the most important is to help the selectively mute student to gain self-esteem and self-concept. To treat h/her as we treat the other children at home, or the other students at the classroom. We should never mention that the children are mute, refer to them with derogative words, which humiliate them, or put them down. Always praise them for their work, even if their success is very minimal. We, teachers, must always keep in mind that it is not the final work of what the child produces, but the learning process that is in between which enriches the life of the child. When we address them, it is very important to try to make eye contact and to smile at them.

Recommendations

The following are results of my findings in the literature review of this topic. These are some of the recommendations for parents and teachers and anyone who is interested in this problem and who wants to help a Selectively Mute Child. I will be very happy if these recommendations can be of any help.

- Parents can do much in helping their child by providing every opportunity for socialization and for speaking.
- If the child makes errors while h/she is talking, do not correct them; remember that what is important here is for the child to speak. Later on, h/she will learn to speak with grammatical correction.
- Behavioral techniques should be implemented in all social environments where verbalizing is difficult. This means that new behaviors will be encouraged while the unwanted behaviors are replaced.
- It will be very useful to first observe the child to find out if there is any problem with

language development that is the cause of the Mutism.

- Parents and teachers must take into consideration that usually when these children do not speak, is because they are using a defense mechanism to avoid the anxiety that comes along when they need to talk in unfamiliar settings.
- Parents should consider contacting their teacher, principal, school psychologist, school counselor or social worker for help in the school setting.
- These individuals play a very important role in assisting families and implementing a consistent treatment plan in school.
- This help requires patience, time, endurance, fortitude and love.
- Sometimes, people that is working together to help a selectively mute student feel anger, and frustration if in spite of all the work they are doing, the conditions persists. In order to avoid this, it is best, if the person that

surrounds the life of the child is always well informed and well educated.

- Although the child should never be forced to speak, it is very important to give h/her encouragement.
- It is very crucial that the people to whom the child uses to speak be involved in any treatment plan.
- It would be very wise to involve the child in h/her own treatment, for instance what kind of rewards. This could help the child to enhance their self-confidence, self-autonomy and the feeling of being in control.
- Parents and alike must understand that that whatever they do to help the child, is going to have maybe slow and gradual results. Maybe the child is going to utter only one word as a response. This could increase to more words or even a whole sentence at a time. Here is when patience comes very handy.

As one can see, Selective Mutism is not an impossible problem to solve. With adequate knowledge, desire to help,

patience, understanding, and love, both teachers and parents can help to solve this malady.

APPENDIX A

QUESTIONNAIRE

QUESTIONNAIRE

The following is a questionnaire from The National Conference of the Anxiety Disorders Association of America in San Diego California on March 26 to 29, l999, which aims the preliminary findings about this condition.

SELECTIVE MUTISM QUESTIONNAIRE (SMQ)

Identifying Code:_____ _____ _____ _____

Month of your child's birthday: (day of your birthday: if your child's birthday is March 6, you would enter 03 in the spaces above. If your child's birthday is May 5 would enter 05 in the spaces above)

Please mark one:

First time completing the SMQ ( )
Second time completing the SMQ ( )

Please, rate how true each of the statements is for your child. Please, consider your child's behavior and activities of the past month. Also note that the terms "talking" or "speaking" refer to verbalization of average loudness. Whispering is rated only on item 30.

AT SCHOOL

1. **My child talks to most peers at school.**
   Always Often Sometimes Never

2. **My child talks to selected peers (his /her friends) at school.**
   Always Often Sometimes Never

3. **When called on by his or her teacher, my child answers.**
   Always Often Sometimes Never

4. **My child asks his/her teacher questions.**
   Always Often Sometimes Never

5. **My child speaks to most teachers or staff at school**
   Always Often Sometimes Never

6. **My child speaks in groups or in front of the class.**
   Always Often Sometimes Never

7. **My child participates non-verbally in class. (i.e., points, gestures, write notes).**

Always Often Sometimes Never

8. **How much does talking interfere with school for your child?**

Not at all Slightly Moderately Extremely

9. **While at home, my child speaks comfortably with the other family members who live there.**

Always Often Sometimes Never

10. **My child talks to family members living at home when other people are present.**

Always Often Sometimes Never

11. **When my child will not talk at home, he/she communicates non-verbally.**

Always Often Sometimes Never

12. **When my child will not talk, he, she asks other to talk for him/her.**

Always Often Sometimes Never

13. **My child talks to family members when in unfamiliar places.**

Always Often Sometimes Never

14. **My child talks to family members that don't live with him/her (e.g. grandparent, cousin).**

Always Often Sometimes Never

15. **My child is willing to speak on the phone to his/her parents and siblings.**

Always Often Sometimes Never

16. **How much does not talking interfere with family relationships?**

Not at all Slightly Moderately Extremely

17. **My child speaks with his/her friends when outside of school.**

Always Often Sometimes Never

18. **My child speaks with other children who s/he doesn't know.**

Always Often Sometimes Never

19. **My child speaks with family friends who are well known to him/her.**

Always Often Sometimes Never

20. **My child speaks with family friends who s/he doesn't know.**

Always Often Sometimes Never

21. **My child speaks to at least one babysitter.**

Always Often Sometimes Never

22. **My child speaks with his or her doctor and/or dentist.**

Always Often Sometimes Never

23. **My child speaks to store clerks and/or waiters.**

Always Often Sometimes Never

24. **My child speaks on the phone with non-family members.**

Always Often Sometimes Never

25. **When my child will not talk in social situations, he/she communicates non-verbally.**

Always Often Sometimes Never

26. **When my child will not talk in social situations, h/she asks someone to talk for h/her.**

Always Often Sometimes Never

27. **How much does not talking interfere in social situations for your child?**

Not at all Slightly Moderately Extremely

28. **My child is comfortable in familiar situations (i.e. my child does not freeze, or become distressed or withdrawn).**

Always Often Sometimes Never

29. **My child is comfortable in unfamiliar situations.**

Always Often Sometimes Never

30. **When my child is in a situation and will not talk, h/she will whisper.**

Always Often Sometimes Never

31. **When my child is reluctant but willing to speak, h/she speaks in an odd voice.**

Always Often Sometimes Never

32. **My child talks when in clubs, teams or organized activities outside of school.**

Always Often Sometimes Never

33. **My child participates non-verbally in clubs, teams, or organized activities outside school.**

Always Often Sometimes Never

34. **Overall, how does not talking interfere with daily living for your child?**

Not at all Slightly Moderately Extremely

35. **Overall, how much does your child's not talking bother your child?**

Not at all Slightly Moderately Extremely

36. **Overall, how much does your child's not talking bother you?**

Not at all Slightly Moderately Extremely

APPENDIX B

WHERE TO GO FOR MORE INFORMATION

WHERE TO GO FOR MORE INFORMATION

American Psychiatric Association
1400 K Street. NW
Washington, DC 20005
(888) 357-7924
psych.org/index.cfm

American Psychological Association
750 1st Street, NE
Washington, DC 20002-4242
Phone: 1-800-374-2721 or (202) 336-5510
www.apa.org

Association for advancement of Behavior Therapy
305 7th Avenue, 16th floor
New York, NY 10001-6008
(212) 647-1890
www.aabt.org

Anxiety Disorders Association of America
8730 Georgia Avenue, Suite 600
Silver Spring, MD 20910. USA
Main # (240) 485-1001
Fax# (240) 485-1035

American Psychiatric Association
1000 Wilson Boulevard, Suite 1825 Arlington, Va. 22209-3901 (703) 907-7300
apa@psych.org

American Speech-Language Hearing Association
(ASHA)
10801 Rockville Pike
Rockville, MD 20852
Voice: (301) 897-5700
TTY: (301) 897-0157
Toll-free: (800) 638-8255, 8:30 a.m. -5 p.m. Eastern Time
Fax (301) 571-0457
E-mail Actioncenter@sha.org
Internet: www.asha.org

Bergman, Lindsey R. Ph.D.
UCLA –NPI- Room 68-237
760 Westwood Plaza
Los Angeles, CA 90024
lbergman@ucla.edu
Freedom from Fear
308 Sea view Ave
Staten Island, NY 10305
(718) 351-1717
www.freedomfromfear.com

National Black Association for Speech-Language and Hearing (NBASLH)
3605 Collier Road
Beltsville, MD 20705
Voice (202) 274-6162, 9 a.m.-5 p.m., Eastern Time
Fax⊗202) 274-6350
E-mail" nbashlh@aol.com
Internet: www.nbashlh.org

http://webdb.nidcd.nih.gov/resdir/resourc.html

National Alliance for the Mentally Ill (NAMI)
Colonial place t\Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201
Phone: 1-800-950-NAMI (6264) or (703) 524-7600
Internet: http://www.nami.org

National Center for PTSD
U.S. Department of Veteran Affairs
116D VA Medical and Regional Office Center
215 N. Main St
White River Junction, VT 05009
(802) 296-6300
E-mail: ncptsd@ncptsd.org
Web site: www.ncptsd.org

National Library of Medicine
Clinical Trials Database
www.clincaltrials.gov

NIDCD Information Clearinghouse.

Obsessive Compulsive (OC) Foundation
337 Notch Hill Road
North Branford, CT 06471
(203) 315-2190
www.psych.org/index.cfm

NIMH Clinical Trials Web Page
www.nimh.nih.gov/studies/index.cfm

'Selective Mutism Anxiety Research and Treatment Center'
(SMART)
Dr. Elisa Shipon-Blum
Executive and Medical Director.
7960 Bustleton Ave. Philadelphia, Pennsylvania 19152
(125) 887-5748
SMGCAN@aol.com

Selective Mutism Group/Childhood Anxiety Network.
National Institute of Mental Health (NIMH)
Office of Communications and Public Liaison
6001 Executive Blvd., Room 8184, MSC 9663
Bethesda. MD 20892-9663
General Inquiries: (301) 443-4513
TTY :(301) 443-8431
E-mail: nimhinfo@nih.gov
Web site: www.nimh.nih.gov

APPENDIX C

ANNOTATED BIBLIOGRAPHY RELATED TO SELECTIVE MUTISM

Annotated Bibliography related to Selective Mutism

Cline, Tony, Baldwin, Sylvia (1994) Selective Mutism in Children. Singular Publishing Group, Inc.

Children who remain selectively mute are the center of this book. It discusses in detail the problem of assessment, treatment and management they need. It also presents a system model of Selective Mutism and the description of a proper treatment for this condition. ISBN: 1565932579

Kratochwill, Thomas R. (l981) Selective Mutism: Implications for Research and Treatment Lawrence Eribaum Associates, Inc

This book is very informative; it provides a lot of information about Selective Mutism. ISBN:

Johnson, Maggie, Wintgens, Alison. (2001). The Selective Mutism Resource Manual. Speechmark Publishing Limited.

This book gives insight in the disadvantage personally and socially of the selective mute child, and how this condition is a great barrier in learning. ISBN: 0863882803

March, John S. (1995) Anxiety Disorders in Children and Adolescents. Guilford Publications, Inc.

This is the most comprehensive volume that deals with anxiety disorders among children. ISBN: 0898628342

Spasaro, Shelia A., Shaefer, Charles. (1999) Refusal to Speak: Treatment of Selective Mutism in Children. Jason Aronson

The book puts the research papers together in one book (one paper per chapter). The book gives information about potential treatment methods, and the results of different treatment methods. ISBN: 0765701251

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