

Can adults who have recovered from selective mutism in childhood and adolescence tell us anything about the nature of the condition and/or recovery from it?

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The literature on selective mutism provides little information on the child's own perspective. Six adults who had been selectively mute were interviewed about their childhood and adolescence. Data analysis led to identification of five themes, each of which has potentially important implications for teachers. (1) Origins of selective mutism: all interviewees reported withdrawal from social interaction at an early age. There was evidence from three respondents that onset of selective mutism was associated with events they had found traumatic. (2) Maintenance of selective mutism: all interviewees reported being strong willed, with a conscious determination not to speak. Selective mutism became a clearly understood and well-defined social role. (3) Determination, social anxiety and loneliness, only two respondents (twins) reported feelings related to social anxiety in childhood, but other symptoms were reported. (4) In the recovery process four respondents reported their own conscious decision to change their current lifestyle as a precursor to starting to speak. (5) Concerning current psychosocial adjustment, four respondents had obtained therapy as adults, though not for selective mutism; five interviewees felt confident in formal, professional settings, but still experienced anxiety in informal, social situations. The data are discussed in light of previous work on selective mutism. In spite of inherent limitations, interviews with adults who have recovered may help teachers to understand both the development of the problem and their own role in helping students to recover from it.

Keywords: *Selective mutism; Recovered adults*

Background and aim

Selective mutism is a condition in which the child does not speak to certain people, often teachers and strangers, in specific social situations, frequently in kindergarten/

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school, while speaking in other situations, such as to parents and siblings at home. The failure to speak is consistent and may last for years. Most reports suggest a mean age of onset of selectively mute behaviour at 5 or 6 years or younger. This varies from 2.7 years (Black & Uhde, 1995) to 5.4 years (Ford *et al.*, 1998). The American Psychiatric Association's current use of the term 'selective mutism', in preference to the former 'elective mutism', reflects a consensus view that the children *select* the people to whom they will or will not speak (APA, 1994).

Selective mutism has low frequency, according to the few available epidemiological studies. Steinhausen and Juzi (1996) argue that the condition affects less than 1% of the population, the prevalence given in DSM-IV (APA, 1994). There are more girls than boys (1.5: 1) with selective mutism (Kopp & Gillberg, 1997). Some 90% of children with selective mutism are mute in school or with strangers (Steinhausen & Juzi, 1996). Around one in four do not speak with children outside the family. One-third exclude specific children from verbal communication. If the child does not talk at home, which is less frequent, it usually excludes the father. Steinhausen and Juzi (1996) found that shyness affects 85% of the selectively mute children. More than one-third are depressed. One-fifth show symptoms of oppositional-defiant or aggressive behaviour. One-third show elimination disorders such as enuresis or encopresis. Sleeping and eating disorders are also quite common. Least frequent are tics or obsessive and compulsive symptoms.

There is controversy about the diagnosis and treatment of this group. Co-morbidity is quite frequently detected in selectively mute children. Kristensen (2002) found communication disorders in 50% of selectively mute children, enuresis in 30% and a developmental coordination disorder/delay in 17% of selectively mute children. Earlier literature focused on the stubbornness or determination of children with selective mutism (e.g. Wergeland, 1979), while currently most researchers explain these children's silence as a symptom of social anxiety (Black, 1996; Anstendig, 1999; Kristensen, 2002). Kristensen (2002) found anxiety disorders in 74% of the selectively mute children, versus 7% in the controls. Nevertheless, criterion E of APA (1994) excludes a diagnosis of selective mutism if it is 'better accounted for' as an anxiety disorder. While some studies have reported a majority of children with selective mutism as showing anxiety symptoms, selective mutism remains relatively rare among children with this diagnosis.

Researchers have been interested in the nature of the psychological dynamics within the families of children with selective mutism. Black and Uhde (1995) describe selective mutism as a familial phenomenon. Kolvin and Fundudis (1981) found a high rate of psychiatric disturbance in the families of these children. Their study does not suggest, though, the presence of a common set of family dynamics. The authors argue that the origins are multifactorial. They suggest that one-third of the parents of selectively mute children show serious or marked reserve and shyness. When serious psychiatric disturbance or major personality problems were considered in combination with serious marital disharmony, it was found that six of the ten families were affected. Wergeland (1979) reported parents of selectively mute children as having unusual personalities and psychiatric problems. In nine of Wergeland's 11 families

there was a striking shyness. Kristensen (2002) found more prior and/or present social anxiety and shyness in the parents of children with selective mutism than in the control parents. This raises the interesting possibility of a familial link between shyness of the parents and selective mutism of the child. The influence of learning and modelling could adequately account for this, and parental taciturnity appears particularly important (Steinhausen *et al.*, 2006).

Kristensen (2002) found four in 54 selectively mute children fulfilling the criteria for Asperger's disorder. Kopp and Gillberg (1997) found symptoms of selective mutism coexisting with Asperger syndrome in one of the five selectively mute children they examined clinically. They suggest that selective mutism could be linked to autistic spectrum disorders. There is, however, a difference in how these two groups are often described by their mothers. Children with Asperger syndrome are often described as solitary, remote and strange, while selectively mute children's parents seem unaware of the child's unusual communication style before it attends kindergarten or school (Kolvin & Fundudis, 1981). Children with Asperger syndrome are also described as showing obstinacy and aggressive outbursts, especially when attempts are made to persuade them to conform. However, the selectively mute child's obstinacy is usually combined with degrees of withdrawal or retreat. According to Kolvin and Fundudis (1981), obsession is almost universal in Asperger syndrome, while this is rare in selectively mute children. Children with selective mutism seldom speak outside the home or at school, while only a few children with Asperger syndrome refuse to speak at school. Another difference, according to the authors, is that selectively mute children seem to use non-verbal communication more than children with Asperger syndrome.

There are two major problems with the literature reviewed above. First, knowledge about selective mutism has developed largely from clinical assessment and interventions by specialists. There appear to have been few attempts to understand the child's interactions at home and at school. Specifically, there is little to guide teachers in their interactions with selectively mute pupils. Second, and arising from this clinical focus, the literature on selective mutism provides little information on the child's own perspective. At one level that is not surprising: by definition, these children are unlikely to talk to teachers at school, nor to psychiatrists or psychologists in a clinic. It does, nevertheless, represent another gap in the literature.

One way to start filling this gap is through talking with adults who have recovered. The rationale for interviewing recovered adults was that:

1. Little is known about the origins of selective mutism, at least from the child's own perspective. Could reports from adults who are now talking throw light on this?
2. By definition, interviewing children with selective mutism is notoriously difficult (though an article on how to help them communicate about sensitive matters is in preparation). Adults who have recovered may be able to throw some light on the experience of selective mutism, even though their memories will be filtered by the passage of time.
3. Very little is known about the process of spontaneous recovery from selective mutism. There have been numerous treatment case studies (Rye & Ullman, 1999;

Cleator & Hand, 2001; Post, 2001; Stone, Kratochwill *et al.*, 2002), but none that investigate the process of spontaneous recovery as reported by people who have been selectively mute.

4. Epidemiological studies show that only a minority of children meeting the DSM-IV criteria are formally referred for treatment as the children often get another diagnosis that may receive more attention in treatment due to a lack of knowledge or experience with selective mutism among professionals (Kennedy, 2004). Hence, information is needed about the adjustment in adult life of formerly selectively mute children/adolescents.
5. Diagnostic controversy (e.g. whether the selective mutism is a form of stubborn behaviour or of social withdrawal) is based on interpretation of clinical interviews and, to a lesser extent, on observations (usually in clinical settings). Interviews with recovered adults may throw some light on the individual's own experience, even though here too memory will be filtered by the passage of time.

This paper is based on interviews with six adults who refused to speak in certain social situations and/or to certain people during their childhood and adolescence. It considers what light can be cast both on the child's experience of selective mutism and on the recovery process, and discusses potential implications for diagnosis and treatment.

Design

Six adults agreed to take part in semi-structured interviews (see Appendix 1), exploring their experience of being mute, social interactions and other people's reactions, self-image and personality, the recovery process and current adjustment. The interviews were semi-structured in order to give the researcher, and the interviewees, opportunity to pursue a promising line of inquiry, while still enabling the researcher to cover all essential issues; questions were derived from the literature and from the researcher's own prior experience of work with children with selective mutism. Items were grouped under seven headings: background information, the mutism, social role and self-image, social interaction and others' reactions, personality and anxiety, recovering and special support, life today. Although all questions were asked, the order varied depending on replies to previous questions. Promising lines of inquiry were followed up with subsidiary questions. Two examples show how the questions were based on the literature or related directly to an issue arising from it. The recovered adults were asked: 'what helped you to start talking?' This was linked to my interest in the special support the selectively mute children need in their interaction within the natural environments of kindergarten and school. They were also asked: 'Did you show other symptoms than the mutism?' This was based on the frequent comorbidity reported in the literature.

Sample and data collection

Selection of sample. The author's appearance on a daytime Norwegian radio programme provided an opportunity sample. Listeners were invited to contact the

author, either if they had experienced selective mutism themselves or if they were parents of children who suffered from it. Selection criteria for the present paper were: adults aged 25 or over who claimed to have recovered from selective mutism; and confirmation of selective mutism in interview.

The six respondents who met these criteria were all female and included one pair of identical twins. They were Elisabeth and Sarah (twins aged 31, both single and students at Master's level); Hannah (45, married, mother of five children, a nurse, who had grown up in South America); Maria (60, married and mother of two children, a museum curator); Linda (48, married and mother of two children, a librarian); and Catherine (33, single, an artist). Pseudonyms are used throughout.

Confirmation of selective mutism. None of the adults who offered to talk about their experience of selective mutism had ever been referred for treatment or diagnosed selectively mute by professional services. None of the women recalled receiving any special support in kindergarten or school, even though they did not speak there. The information they offered, though, indicated that they met the DSM-IV (APA, 1994) criteria for selective mutism.

The twins could only speak to each other and their mother for the first two or three years after they had learned to talk. They started to talk to their father at the age of 4 or 5, but could never call him 'dad'. Their refusal to speak at school was consistent till the 4th or 5th grade, but then they gradually started to talk to more and more people and, when they decided to go to separate high schools, they could talk to everyone in school.

From the age of 7, Hannah spent four years at a boarding-school in South America far away from her parents. She refused to speak to anyone in school, except her best friend. She would speak to no one when strangers came to the house.

Maria was born in France and grew up during the Second World War. She had not started to speak at the normal age, because she had no adults to talk to. Her mother was terrified by the war and was depressed. Her father was away in the army, and did not return until 1946. He had no job to return to in France and started to interact with the 4-year-old Maria and taught her some words. However, he then sexually abused her until she was 6 years old and entered school, and she became even more confused about adults. She was terrified by her authoritarian teachers and would say nothing to them in school. She said that she could not even think there, because of her anxiety. She was always alone and very lonely. She started speaking only when she moved to Portugal at the age of 19.

Linda was a highly intellectual child who learned to read when she was 4 years old and had read all books in the children's department of the public library by the age of 12. She talked a lot when she was 1 or 2 years old, but then she gradually withdrew more and more. She described herself as trying to protect her personality, as nobody believed that she had the capacities she actually had. At school she could learn her homework by heart and recount it, and give written presentations, but she could not speak to anyone other than her siblings and some friends who admired her for her

abilities. She could not speak to strangers visiting her family. Her father frequently punished her physically. When she was 15 years old she tried to change her personality from being highly in control to feeling free. She moved to another environment and stopped talking to her father for one year.

Catherine could speak to her sisters and parents, but could not speak in kindergarten from the age of 2 to 4. The mutism probably started when she had to change kindergarten when she was 2 years old. According to her mother, Catherine had advanced language development from the age of one and a half. When she was 2 years old, she even stopped talking to her much-loved grandfather. One of her two elder sisters also showed selectively mute behaviour during her childhood. The sister refused to speak, eat and go to the toilet. Catherine could not speak to strangers visiting the home or at the library where her mother worked, but she could sometimes communicate through songs and drawings as a preschool child, because the communication was indirect. Other pupils bullied her in school. She was highly self-conscious from an early age, and did not want others to focus attention on her.

None of the adults had suffered as children from a communication disorder, such as stammer, nor did any of them recall anything consistent with a pervasive developmental disorder, schizophrenia or other psychotic disorder.

Conduct of the interviews. The interviewees received an information letter before the interview, to which they gave their informed consent. The interview guide was sent to the women in advance. All six respondents said that they needed to prepare in order to give themselves the courage to speak as freely as possible. One of the twins was initially a little nervous about the tape recorder recording everything she said, but she did not withdraw the consent given previously, and talked freely after a very short time. The twins were living together at the time and were interviewed together. Interviews took place mainly in the respondents' own homes without others present, so that the women were in familiar surroundings where they could feel relaxed. One of them wanted to be interviewed in her mother's house in order to help her remember more about her past. The interviews lasted around two hours (mean 117 minutes), and produced a total of 144 pages of transcriptions, with a mean of 29 pages.

Data analysis

The software program, Nvivo, (Richards, 2002) was used to assist in the organization of themes emerging from the data. There was a choice between reporting separate case histories or adopting a theme-based approach when presenting the results. A theme-based approach was considered preferable as it allowed a sharper focus on:

- common elements in the participants' backgrounds;
- aspects of selective mutism that have attracted relatively little attention in the literature, but are likely to be of particular interest to special educators;
- aspects that are the subject of debate and/or controversy.

Results

Five themes emerged from data analysis: origins of selective mutism; maintenance of selective mutism and the importance of social role; determination, social anxiety and loneliness; the recovery process; and current psychosocial adjustment. Direct quotations illustrate points arising in each theme.

Origins of selective mutism

None of the women could remember precisely when the mutism started, but they all remembered that they had gradually withdrawn more and more and developed a role as the silent girl. Elisabeth and Sarah's parents told them their mutism started even before they could speak. They cried when strangers or other people tried to hold them, and they were very afraid, even of their father. The twins made up special rules for their own behaviour. These, with the mutism, were used to exclude others, and they became highly dependent on each other.

Linda felt different to others, because she was very bright. She withdrew and started to take care of herself when others did not believe that she had the knowledge she actually had and laughed at her. Additionally, she was physically punished by her violent father during her childhood.

Trauma is little discussed in today's research on selective mutism, but all the informants described incidents they had found traumatic in their childhood, and in three cases it was associated with the onset of selective mutism. Maria was born during the Second World War, and her mother was suffering from depression. Maria locked herself in her own world and described her silence as a way of protecting herself against a chaotic world. She had no one to speak to until her father returned from the war, but then he sexually abused her and her mother did not help her. Catherine's change of kindergarten at the age of 2 seemed to lead to her selective mutism. She became ill, with spots all over her body, and had to stay home with her mother for five weeks. Later on, she experienced bullying in school. Hannah's selective mutism started when twin siblings were born when she was 2.5 years old and she became very jealous. She refused to speak in the years when she was separated from her parents at a boarding-school in South America.

Maintenance of selective mutism and the importance of social role

The environment reinforced the girls' mutism in a variety of ways, and they learned that it was best to stay silent. One crucial element was other people's negative expectations of them being mute, which they conformed to. Elisabeth and Sarah found that a formal situation such as the classroom was difficult to handle. They could not talk there and others did not expect them to either:

I think they just got used to or thought that, OK, that's how they are, and there's not much to do about it. They just accepted it, they gave up. (Elisabeth)

Thus, they came to be seen as the silent girls. Later on the other pupils bullied them, because they were afraid of so many things. Yet, the effect of bullying was not to encourage Elisabeth and Sarah to start talking, but rather to strengthen their need to remain in control and thus retain their separate identity as the girls who did not speak. Sarah and Elisabeth thought that their behaviour had become more compulsive because their parents constantly criticized them.

During their childhood, they felt that everyone else was their enemy and it was 'them against us'. If they happened to say something or behaved in a new way, all the women found it difficult if people remarked on the change. People just had to behave as though everything was the same if they were to change their communication pattern. Elisabeth and Sarah felt that they could not start to speak, because if they did, then the others would 'win'. They found it difficult to be like everyone else. It was embarrassing, but at the same time they wanted to be like the other pupils. They used each other to speak through if they wanted to say something to their father. They used selective mutism to create a joint identity that excluded other people, a phenomenon similar to reports of twins having their own twin-language (Bowen, 1999).

Maria said that she never actually began to speak when she was small, because in wartime there were no adults to speak to. One time when she happened to say something to the pupil next to her in the classroom, she was punished by the teacher and learned that it was best to say nothing. Hannah had a best friend that she talked to at the boarding-school. She talked for Hannah, because Hannah would not say a word to the housemother. She could nod or shake her head, but she never spoke when the housemother could overhear her. Hannah never found it hard to be consistent about withholding speech. Linda felt that she had to make herself invisible and hide her capacities, because she was afraid of being laughed at by teachers who did not think that she actually had the knowledge she had. Catherine felt that it was impossible to start talking after she had not talked for two years, because that would undermine her sense of self:

It wasn't something I wanted or something conscious, it just turned out that way. It was just like a huge mountain growing bigger and bigger. It was impossible to force that mountain. You can't suddenly start to speak when you haven't spoken for two years. (Catherine)

Determination, social anxiety and loneliness

All respondents were determined not to speak just because other people wanted them to (e.g. the twins' refusal to let others 'win' if they talked, and Catherine's feeling that starting to talk would undermine her sense of self, referred to above). The respondents said that they feared changes, because they did not know how to cope with them. They did not feel comfortable about others expecting certain behaviours from them. Even today, if someone expected the women to speak in an unfamiliar situation, it could make them feel stressed and unable to talk.

Only two respondents (the twins), reported that they had felt social anxiety during childhood:

We were terribly worried, especially about new situations, unfamiliar situations, different situations; we were scared to death, new people, especially men and dominating people, authoritarian people, formal situations. (Sarah)

Linda did not characterize herself as worried and socially anxious when she was small, but because others did not understand her and bullied her, she withdrew more and more in social situations and her self-esteem became lower and lower. The other respondents withdrew more and more too as they feared that they had to talk.

When their identity as selectively mute was established, five respondents implied that they felt lonely and isolated from adults and/or other children. This feeling of loneliness co-existed with the determination not to speak, and reinforced it. Three respondents had made suicidal gestures. Linda felt that she had learned all there was to learn by the time she was 10 years old. She described going out on the ice in winter when she was 14 years old to try to drown herself. Maria remembered feeling very lonely during her childhood. She did not understand what was going on around her and felt that no one cared about her. Because of the war, adults had enough worries of their own. Maria gave up trying to talk to adults after repeated disappointments. She walked around the garden or cycled on the dykes to survive. Receiving no feedback, she had been in real danger of losing any sense of personal or social identity. Maria felt that she needed to make a strict programme for herself to survive during her adolescence. She felt that she had to be determined in order not to lose herself.

The recovery process

The interviewees' were determined to maintain their mutism, because they could not handle people's reactions to the change if they suddenly started to speak, but the same determination helped them to recover from their silence. When they consciously decided to speak, they stuck to their decision. Linda had to change environment in order to start speaking. She sought out a music club and built up an alternative personality there. When no one had any special expectations of her communication, it was easier to start from scratch. She realized that she had the capacity to change, and eventually decided to when she was 15 years old. At the same time, she refused to speak to her father for a year, consciously punishing him with her silence, in retaliation for his physical punishment of her.

Hannah and Catherine were the only two respondents who did not identify a specific time at which they made a conscious decision to start talking. They gradually changed their patterns of communication and talked to more and more people, as they grew older and changed school conditions. In contrast, the twin sisters decided to go to separate high schools in order to start speaking in a new environment where no one knew them or had any special expectations of their behaviour. Their sense of self was strong enough to decide jointly how they could start to speak. They felt relieved about being independent and no longer locking each other in a pattern of silence.

When Maria decided to move to another country, at the age of 19, she discovered that she was actually extroverted and not withdrawn, as she had always felt when

growing up in France. Until then other people had defined her as mute, but when she spoke to people in the new country, she found that they reacted differently and expected her to talk:

I didn't actually know who I was. I thought it was normal, that things are like this. It's only the huge inner anxiety that gave me a clue that this is not normal and I have to do something. The only way out was to travel away, but before that I thought that this is life. I didn't know anything else. (Maria)

Current psychosocial adjustment

Four respondents had obtained the therapy in adult life that they never received during their childhood. Maria had psychoanalysis to reduce the effect of the neglect and sexual abuse she had experienced when she grew up. She felt that she needed psychoanalysis because she was not able to describe her early life in words. The therapy tried to recall Maria's childhood feelings without any speech from her. Maria wrote many notes when she remembered blocked events, and painted themes from her childhood.

The women still have problems today, which they attribute to their childhood experiences and their personality. Three interviewees were married and had two to five children. The respondents felt it was sometimes difficult to show their emotions in the upbringing of their children, because they had not experienced this in their own childhood. They described their children as shy, but they were not as consistent as their mothers had been about refusing to speak. One child had once been referred to child and adolescence psychiatry services due to emotional problems. The respondents thought that they had not fully recovered, but they had found ways to handle their lives and avoid situations provoking anxiety and withdrawal.

Elisabeth and Sarah were the only women who clearly felt that they had experienced social anxiety as children, and this continued today. They had received therapy as adults to reduce their anxiety, caused partly by bullying at school.

Yet even now the women had great problems if they were the focus of attention. Hannah described herself as an insecure person who had to be sure she would manage before she tried anything new. She did not participate in discussions if she had not previously decided to speak. Others would notice that she suddenly said something, and she was afraid of hearing her own voice. Linda was afraid of talking privately on the telephone, but not if it was about a professional matter. She had no problems with giving lectures in front of 250 students if she was well prepared:

I work at a library and there we have to communicate with and teach students. We may have 250 students in the hall. Some people think it's hard to stand in front of so many. In addition, lectures are filmed for other universities. But I have no limits, because as long as it is controlled by me, I can do it. It's no problem. No one can disconcert me as long as I'm in control. (Linda)

They all talked about problems with going into relationships with men in adolescence and adult life. Even though these women can now talk, they feel that their main personality characteristics remained the same. Catherine talked about her strong

sensitivity, empathy and self-consciousness both as a child and now. She had to look people in the eye in order to find out if she could talk to them, and she easily scanned the mood of people she was with, and the atmosphere. She felt that she had responsibility for interactions with others.

Discussion

Methodological considerations: validity and reliability of the interviews

I had to rely heavily on the constructs of the interviewees themselves when analysing the retrospective interviews. None of the women could remember when their refusal to speak actually started. Obviously, it is possible that they could have forgotten important issues from their lives as time passed, or they might have held something back. For instance, only Maria reported sexual abuse by her father. Catherine's elder sister, though, was said to have behaved strangely by refusing to speak, go to the toilet or eat, which could imply neglect and abuse. Nevertheless, enuresis and encopresis are quite common among children with selective mutism (Steinhausen & Juzi, 1996; Kristensen, 2002). Steinhausen and Juzi (1996) also reported eating disorders as a common feature in selectively mute children. The women will inevitably have interpreted their past experiences subjectively. One can never claim objectivity from what is essentially an oral history of the individual's own childhood. For example, Linda's brightness has to be inferred from her own account.

Care is also needed in interpreting events from so many years earlier. For example, Linda's obsessive reading, and her responses to bullying at school and her withdrawal from social interaction with other children, could possibly be symptoms of Asperger syndrome. This has been reported in selectively mute children (Kopp & Gillberg, 1997). Maria's speech was highly intellectual when she did manage to say something in her childhood. She referred in the interview to an incident when she was around 4 years old; she knocked on the door of an old couple in their neighbourhood and as they opened the door she asked what was the point in living. They tried to talk about something else, and she said that she felt misunderstood and disappointed, and gave up trying to talk to adults after this. Her loneliness and withdrawal in childhood and adolescence could also be seen as symptoms of Asperger syndrome, but neither Maria nor Linda appeared to have difficulty relating to the author, nor did they report having difficulty in understanding the point of view of others in their lives. So, Asperger's is not likely to be relevant.

In view of the reliability and validity problems inherent in self-report data on events many years earlier in childhood or adolescence, triangulation with other data sources was essential. One of Catherine's two elder sisters (not the one who refused to speak, eat or go to the toilet) and her mother were also interviewed, for she thought they could fill in any gaps. When they described the same incident, the accounts were consistent, but the feelings related to the incident varied. The twins, who were interviewed together, remembered different episodes from their lives, and discussed them. Two interviewees had written notes about their childhood experiences during the past

few years, which they read from during our conversation. They used the notes in their description of disturbing events in the past. Two of the women showed me photographs of themselves as a child, and remarked that they looked withdrawn. One interviewee read from teachers' evaluations of her from the time at school, which said that they thought she lived in her own fantasy world.

Trauma

The current literature on selective mutism does not seriously focus on trauma as an important reason why children develop selective mutism. Selective mutism can occur in any vulnerable child, but it has to be reinforced by the reactions of others. All the women in the study reported incidents that they had found traumatic during their childhood and adolescence. They had experienced aggression, violence and psychological neglect or sexual abuse from their parents, been separated from their parents for months at a boarding-school, grown up during wartime and been bullied at school. Perhaps teachers and other professionals should give greater prominence to trauma in the family as a possible precursor to the silence and withdrawal of these children, rather than thinking of selective mutism primarily as an anxiety disorder.

Social anxiety/stubbornness

By consistently refusing to speak for several years, selectively mute children demonstrate great persistence. At the same time, most authors describe them as extremely shy and socially anxious. Although there has been debate in the research literature about whether selectively mute children are stubborn or socially anxious, the interviewees talked about both motives simultaneously. There was little evidence of social anxiety as a major aspect of their personality in childhood. The respondents withdrew more and more from social situations. Elisabeth and Sarah felt that if they spoke, others would 'win'. That is consistent with stubborn behaviour, but they also characterized themselves as anxious in social situations. This illustrates the problem in the debate about whether selectively mute children cannot speak or will not speak. Stressful experiences, combined with adults who did not recognize their needs, were frequently mentioned by the respondents as causing their gradually stronger withdrawal from parts of the social environment. Five of the respondents reported having felt lonely as children, and this was more important for them than social anxiety. The sense of loneliness reinforced the selective mutism; because they felt lonely, they had to cling to what they had—i.e. their identity as a selectively mute child who was nevertheless strong enough to resist pressure to speak from adults and/or other children.

Maintenance of selective mutism—lack of response from teachers and other adults

Even though damaging experiences may have triggered the mutism, there were probably other mechanisms that maintained the pattern. There is little doubt that other

people's reactions and expectations strengthened the mute behaviour. They met little understanding from teachers and other adults. The women focused a lot on their social role and identity as the silent girl after years without any speech, and they did not feel they could have coped with the attention it would provoke if they were suddenly to start to speak or begin to participate in activities they were not used to taking part in at school. It became almost impossible to change behaviour in a familiar environment. Because teachers did not show much empathy or understanding of their silence, they were not invited to express themselves in school. From the teachers' perspective, they had not verbalized any demands, so it could have been easy to think that they did not need any special support.

Four of the adults in the study had been bullied by other pupils at school. This led to highly self-controlled behaviour and they feared others' expectations and demands. They were highly conscious about what they could do, what they could not do and how others would react. The twins regretted that their teachers had not tried to help, because they knew best what they feared and therefore what could give them the courage to dare to try new things. They wanted the teacher to tell the other pupils about their problem while they were present in the classroom, not when they were absent. The respondents suggested that teachers should observe how the other children communicated with the selectively mute child, to prevent bullying and stigmatizing as the silent girl or boy.

Other symptoms

The twins reported having social anxiety, both when small and as adults. Maria reported depression and loss of identity during childhood. Linda showed withdrawn and suicidal behaviour and Catherine reported acute self-consciousness. The other symptoms seemed to appear *after* the onset of the selectively mute behaviour. This indicates the importance of early recognition of the problem (Kennedy, 2004) and treatment.

Selective mutism as a self-protective response

By refusing to speak, the women seemed to gain control and protect their autonomy in circumstances that they experienced as abuse, neglect and bullying. As children, the informants felt they had missed a positive adult role model with whom they could talk. The data suggest that there may be an important sub-group of selectively mute children whose mute behaviour is a response to neglect and/or abuse. The parents of such children would perhaps be unlikely to seek professional help, in striking contrast to other parents who press strongly for it.

To understand how selective mutism can be a self-protective response, it may be important for a teacher or other member of the diagnostic team to visit the child at home and observe the daily interactions in the family. In addition, letting the child express her/himself through drawings and writing may help in detection of events at home or at school to which selective mutism may be at least a partial response.

The importance of the child her/himself deciding to talk

An important issue from the data was that four of the women started to speak only after making a conscious decision to break their silence. They used their determination positively to change their communication. The twins decided to go to separate high schools; Linda changed her environment by attending a music club and building up an alternative personality in her spare time, and stopped talking to her father for one year; and Maria moved to another country. Hannah gradually started to speak as she moved from the boarding-school in South America to an ordinary school in Norway. Catherine was mute for two years in kindergarten, but then gradually started to speak in school. Elisabeth and Sarah claimed that no person could ever have told them to start speaking, because they would never have allowed others to 'win'. By talking, they would have become like everyone else and people would remark on the change; that frightened them a lot. They had to see the point in speaking on their own and find their own motivation for breaking the silence. Nevertheless, the twins realized that the role of teachers can be critical. Teachers can help to break down barriers to communication, usually by an informal, non-pressurizing approach, but they can also make the barriers more impenetrable.

Conclusion

The interviews revealed important elements in the interviewees' background, such as gradually increasing withdrawal and loneliness in social interactions, a social role and identity as the girl who did not talk, a combination of strong determination and self-awareness and experiences of trauma and anxiety arising from them, and the development of selective mutism as a self-protective response. Family relationships were complex and the respondents reported little understanding or support from teachers and other adults. In starting to talk after years of selective mutism, the individual's own, conscious decision was crucial; and they reported that they had needed to change some aspects of their environment in order to avoid familiar people's expectations and reactions. Finally, although all informants talked fluently throughout a long interview, three were currently receiving psychological treatment. This suggests the importance of a holistic approach to treatment. Overcoming the block on expressive speech may reveal other problems that have developed during the period of silence.

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Appendix. Interview guide: the perspective of the mute child

A crucial way of getting to know the child's own experience of being mute may be to listen to what persons who have experienced this problem themselves as a child can tell you about their experience.

Background information

- Age;
- Gender;
- Civil status;
- Education/profession;
- Interests.

The mutism

- To whom and in what situations could you, or could you not, speak? (The speech pattern.)
- How did the mutism start, and how would you characterize it?
- For how long did it last?
- What do you think was the reason and motive for your selective mutism?
- What did you talk about and what did you not talk about?

Social role and self-image

- How would you describe yourself then and now? (Temperament, vulnerability, behaviour, motivation.)
- How did being selectively mute make you feel? (The meaning for the individual.)
- What role did you have in the environment?
- What do you think was maintaining the mutism?
- Did you feel different?

Social interaction and others' reactions

- How did the people in your surroundings act towards you and your selective mutism? (Family, friends, teachers?)
- What feedback did others give you?
- How and in what situations did you contact others?
- What characterized those adults and children you felt comfortable being with?
- What was your social life like in your sparetime as a child and teenager?
- What expectations did you have/do you still have of others?
- Was there anyone you felt dependent on?
- Do you remember anything making things worse for you? (Situations, persons, events?)

- What did you do to avoid unpleasant situations?
- What do you remember as a good situation?

Personality and anxiety

- Did you show other symptoms than the mutism?
- Did you experience any social anxiety or pressure in relation to speech?

Recovering and special support

- What helped you to start talking?
- Do you remember anything from the time after you started talking? (Others' reactions? Your own experience?)
- In what way were you included when deciding approaches to facilitate your talking?

Life today

- How does your history as a selectively mute child or adolescent affect you today? (Relations with friends, family, professional life, interests?)
- What kinds of help would you like in your life today, if any?

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