Title

Dental Care for Children with Selective Mutism

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Abstract

Selective Mutism (SM) is an anxiety disorder which is characterised by a consistent failure to speak in certain social settings where the child is expected to speak, whilst in other situations, speech is normal. It often starts in childhood and is thought to affect around 1 in 140 children in the UK. Recognised and treated early, SM can be overcome, but left untreated it can lead to long-term problems. It is thought to be caused by a complex interaction between various vulnerabilities such as genetics, temperament, environment and neurodevelopmental factors. Treatment methods are variable and can include non-medication based therapies such as behavioural or pharmacotherapeutic therapy.

This paper specifically addresses the child with SM. Few professionals are trained in dealing with SM or have very little knowledge of the condition. SM awareness for parents and professionals along with appropriate information and intervention techniques are vital. For children with SM, dental visits can prove challenging. Each child is unique in how they present in their difficulties. A child attending the dentist for a dental problem or a routine examination, may not yet be diagnosed with SM and so knowledge of the condition and appropriate services available are important. The dental team should understand the possible modes of therapy that the child is receiving and work with the principles during the dental appointments. Simple strategies such as asking the parent how best to communicate with the child, understanding what makes them feel at ease and if the child have any other phobias or anxieties can help.

What is Selective Mutism?

Selective Mutism (SM) is an anxiety disorder which presents as a failure to speak in social settings where an individual would normally be expected to speak, whilst in other situations, speech is apparently normal[1]. The social context in which the child typically fails to speak is at school with teachers or classmates, whilst in the home setting with parents and siblings; the ability to engage in conversation appears to be normal. Children who are completely silent in those situations are considered to have high-profile SM. Not all children with SM present with complete silence - they may respond with short or mono-tone utterances but do not initiate conversation. These children are considered to have low-profile SM.[2]

There is evidence to suggest that the behaviour of others can unintentionally strengthen SM. This may happen for example, if the child is pressurised to speak or has been criticised or humiliated for not speaking[2]. The avoidance is reinforced by behaviours such as missing school or by others speaking on their behalf.

The impact of SM can be considered so profound, that some view it as a phobia[3]. Parents of children with SM invariably report an increasing resistance to speaking and a reduction in the number of people with whom the child will speak comfortably. They may become less willing to attend certain social situations. Similar to a phobia, this can become distressing and have significant disruption to life. It affects the child’s ability to ask for help or show their true potential at school; seek directions if they are lost; or communicate their pain or discomfort to healthcare professionals. If SM is recognised and treated early on, the condition can be overcome[4,5]. However, left untreated or inappropriate treatment can lead to long-term problems in adulthood[6,7].

SM was first identified by Kussmaul in the 19th Century who named the disorder *aphasia voluntaria*, suggesting that individuals would choose not to speak in certain situations. It was then renamed *elective mutism* in the early 1930s[8]. Researchers and practitioners started to recognise the key role anxiety played in the condition. Consequently, SM was placed in the Anxiety Disorders section in the DSM 5[1].

Prevalence and Background

SM is thought to affect approximately 1 in 140 children[9,10]. There is however a huge variation in the reported prevalence rates in the literature, as high as 2%[11], while other studies report a prevalence of 0.033%[12]. This variation is due to the type of study, the age range of the children, whether the sample was a clinical or community population and the different criteria used to diagnose SM[13].

The prevalence is reported to be slightly higher in girls than boys, with an average ratio of 2:1[14]. Children from bilingual immigrant backgrounds are considered to be four times more likely to develop SM than those of monolingual native backgrounds[10]. Children who are bilingual and display high levels of anxiety are more at risk of developing the condition[15].

SM is often seen as a 'young child' disorder with the age of onset usually between 2 and 4 years[8] but the condition may go undiagnosed for some time with an average age of five to eight years at diagnosis. A main reason for delayed diagnosis is that the SM often doesn't happen at home and becomes apparent after starting school. Similarly, mutism may go unnoticed by teachers or may be dismissed as shyness, delaying referral to appropriate services and early intervention.

Estimate prevalence of adults with SM are 1 in 2400[6]. Some children may outgrow the disorder spontaneously for reasons which are unclear. However, two longitudinal studies have shown that SM continued into adulthood in 42-61% of individuals who had received delayed intervention (on average, 5 years post-onset)[16,17]. Adults with SM have high unemployment rates[18], other co-morbid mental health conditions such as phobias[17] and depression[6,16]. Although there are adults with SM, this paper specifically addresses the child with SM.

Symptoms

A diagnosis of SM (DSM-5 *Diagnostic and Statistical Manual of Mental Disorders*, American Psychiatric Association 2013[1]) is made based on the following criteria:

- A consistent pattern of not speaking in specific situations where speech is expected (e.g. to teachers at school and peers in social situations) while being able to speak freely in other situations (e.g. to close family members at home).

- This lack of speech has a significant impact on the individual’s education and social interactions.
- This pattern has lasted over a month, not including the first month of a new environment (e.g. school).
- This pattern of mutism is not due to a lack knowledge or experience of the spoken language (e.g. learning an additional language), nor can it be better explained by a communication disorder (e.g. stammer) or autism, although these conditions can co-exist with SM.

Selective mutism can be thought of as a ‘fear of speaking’ or ‘fear of their voice being heard’. Words typically used to describe children with SM include being ’frozen’ or ‘like a deer in the headlights’ facial expressions[19]. This fear and anxiety may lead to the child avoiding behaviours that invite verbal interaction or situations where there is an expectation to speak. Consequently, some may not wave or greet people and many may display inadequate eye contact. Others may not want to go to birthday parties, afterschool activities or medical appointments. Some may be reluctant to separate from their parents or a friend. Furthermore, this fear and anxiety can lead to physical symptoms including pain or discomfort and can affect the child’s communication performance as opposed to communication competence. Consequently, they may be slow to respond even to simple questions or instructions. They may appear to lack concentration. Some may even be eager to answer or respond but they feel a sudden tightness in their throat rendering them unable to speak. These behavioural patterns are consistent and do not fluctuate from day to day. Interestingly, children with SM can function very normally in a confident or happy manner, in a situation where speech is not required or other forms of communication can be used (e.g. body language, gestures, signing, writing, texting or typing).

When adults and peers are focused on ‘speaking’ as the main form of communication, they often miss the opportunities to understand the child and are left unsure about what the child is thinking and feeling. Consequently, over time the child with SM may accumulate unmet emotional, educational, or medical needs.

Comorbidities and associated factors

Clinical diagnosis of SM could be further complicated by a number of associated disorders. Children with SM are likely to have another anxiety disorder (74.1%), the most common being social anxiety disorder, separation anxiety and specific phobias[20]. Developmental disorders or delays in cognition, motor and communication skills are also prevalent in this population (68.5%)[20]. With respect to communication development, studies have shown a range of 10-50% of children with SM having comorbid speech and language problems[21]. Other conditions linked to SM include depression, panic disorders, dissociative disorders, obsessive compulsive behaviour and Autistic Spectrum Disorders (ASD) [22].

Autism spectrum disorders is characterised by difficulties in social interaction and non-verbal communication. It has been suggested that 7.4 percent of children with SM also met the criteria for Asperger's,[20, 23] which is now considered part of autistic spectrum. The behaviour of inhibited talking and social interaction in autism and speech and language disorders can look similar to SM. Therefore, it is important to differentially diagnose whether the child has autism, a speech and language disorder, SM or a combination of the three. It is clear that children with SM are a vulnerable and heterogenous population.

Causes and risk factors

There has been no single identified cause of SM. Viana et al suggested the developmental psychopathological pathway as a perspective that considers the genetic, biological, neurological, cognitive and interpersonal influences that shape the condition[8]. This view suggests that SM is not formed by one variable but a complex interaction between various vulnerabilities such as genetics, temperament, environment and neurodevelopmental factors[8,24,25] which heighten the probability of the disorder developing and thereby explaining the heterogeneity of the SM population.

Diagnosis

Clinical assessment of SM must be comprehensive in order to reach a diagnosis. The lack of speech with strangers rules out the child as a primary source of information. Useful information can come from the parents and school teachers. The wider team of health professionals can include paediatricians, psychiatrists, clinical psychologists, and speech and language therapists.

Parental accounts of the child's medical history including prenatal and perinatal development helps to screen for neurological and speech and language development and to assess milestone targets. The clinician will also directly observe the child's level of social interaction, ability to establish friendships, participation in social activities and overall, to gauge the level of inhibition. Direct observation by the clinician of the child in various environments, namely home and school, will provide valuable information about the child's speaking habits. Observations by school teachers are important and they may have insight into strategies that help the child engage, participate and communicate during activities.

As part of an assessment, psychiatric symptoms will also be screened for using a structured diagnostic interview tool with the parents to rule out other conditions such as schizophrenia or learning difficulties that would impede speech. Other explanations for inhibited speech such as shyness, childhood trauma and neurological injuries should also be explored. The Anxiety Disorders Interview Schedule for Children and Parents is a semi-structured interview that is used to assess not only SM but also many other disorders[26]. Physiological causes for lack of speech could lie in undiagnosed hearing difficulties and so this should also be explored as part of the assessment.

Management

Speech and language therapists and psychologists play a significant role in the assessment, diagnosis and treatment of SM. However, poor awareness and debate about professional remit and ownership of the condition leaves many children 'falling through the gaps' of service provision[27]. In the UK, there have been several speech and language therapy services developed to focus on early recognition and intervention, plus communication between home and school[26]. Some services are identifying children and providing intervention on average before the age of 5 years[28,29]. Treatment has moved away from programmes which focus on the child only and now recognise the role of the parents and the school environment[5,30].

Not all NHS Speech and Language Therapy and Child and Adolescent Mental Health Services (CAMHS) are funded to treat SM yet. There is no specific guidance for SM and so General Practitioners and other HCPs may need to use the NICE guidance for Social Anxiety Disorder[31]. The condition should be identified by schools with the help of the Special Educational Needs (SEN) support system.

Effective management of SM requires early identification of the condition; to educate all those involved with the child as to the nature of the condition, adaptation of identified maintaining factors and introduction of a behavioural programme. Early intervention significantly improves the prognosis of SM[5,32,33] and reduces the risk of secondary complications such depression and lack of self-esteem[2]. The options for treatment are variable and described below.

- Behavioural therapy

This approach uses multiple modes that must account for the symptoms in the broader context of the child's environment. Specific techniques used in behaviour therapy include[5]:

- Stimulus fading
- Shaping (prompting)
- Token procedures
- Contingency management
- Reinforcement
- Self-modelling
- Response initiation
- Defocused communication[6]

The most common behavioural strategies are stimulus fading and shaping. Each are often combined with contingency management. Initially, the verbal and non-verbal negative reinforcement that sustains the SM behaviour must be addressed. For example, a teacher not asking a child to engage in a group discussion is a form of negative reinforcement and allows the child to sustain the silence.

- Family therapy

In recent years studies have acknowledged the importance of involving parents in treatment for SM. This is particularly true for exposure-based tasks, as they are able to sustain and reinforce the skills on a day-to-day basis, especially when family factors have been identified in playing a role in the development of SM.

- Medication-based therapy

Given the association between the SM and social anxiety, pharmacotherapeutic interventions have a huge role to play in treatment. The main two medication groups used are

- Anti-depressants
- Anti-anxiety medications

Selective serotonin reuptake inhibitors (SSRIs), fluoxetine in particular, have been shown to reduce SM symptoms. SSRIs have disinhibitory adverse effects and therefore are thought to work in treating SM which is considered an inhibitory behaviour[34]. Dummit et al found that children with SM treated with fluoxetine for a period of nine weeks displayed reduced levels of anxiety and mutism[35]. Monoamine oxidase inhibitors (MAOIs) have been used to treat SM but are associated with more food and drug interactions and so are less favoured.

It is important to consider that many of the studies exploring medication-based interventions for treating SM are based on case reports with limited sample sizes[36]. This can make it difficult to draw conclusions about their effectiveness.

Support for parents of children with SM must not be overlooked. Often they can feel judged by people who have a poor understanding of the condition. They may be blamed for not engaging enough socially as a family, going to work, marriage breakdown etc. Parent workshops have been set-up to create blame-free and supportive environment, free of judgement. Similar to management of phobias, talking openly and calmly in a positive manner with children about their fear is encouraged.

Useful resources exist including the Selective Mutism Information and Research Association (SMIRA) website (www.selectivemutism.org.uk), which is available for children, families and professionals. SMIRA is a UK registered charity set up initially to support families with selectively mute children. It is extended to provide information to health and education professionals, have social media groups and host an annual conference. Another useful resource is the ISpeak (www.ispeak.org.uk), a website providing support for teenagers and adults with SM.

SM and Dentistry

Very few professionals are trained in dealing with SM and many have very little knowledge of the condition. Early intervention is crucial to completely treating the condition in the first few years, making SM awareness for parents and professionals along with appropriate information, training and intervention techniques vital.

Healthcare Professionals may mistake silence in children with SM as ‘rudeness’ or defiant behaviour. It is important to recognise that children with SM suffer from anxiety and have behavioural inhibition leading to fear of making mistakes and many may have comorbid social anxiety disorder with an underlying worry of social judgment, and uncertainty about one’s ability to be liked and accepted.

Every child with SM is unique in how their difficulties manifest. A child attending the dentist for a dental problem or a routine examination, may not yet be diagnosed with SM. It is helpful to assess the patient’s medical history form where the parent may have disclosed a SM diagnosis. Medical history forms should be adapted to include appropriate questions for children’s additional support needs.

Dentists should be aware of the modes of therapy that the child is receiving and working with the therapeutic principles during the dental appointments. A simple phone call with the parent ahead of a dental appointment may be useful in facilitating this. Asking a series of questions will help the dentist decide how best to communicate with the child. For example, finding out what makes the child feel at ease and finding out more about the child’s interests.

It is also important to establish whether or not child has any other phobias or anxieties that could cause distress during the session. Asking the parent about what form of communication the child would feel most comfortable with, would be helpful in preparing for the appointment (e.g. gestures, signing, use of visuals, or if old enough writing, texting or typing). It is vital that the dentist recognises that the child may have made progress in an intervention for SM and may be able to answer in single words or sentences. Parents may also be trying different strategies as part of the programme and the dentist visit could be another exposure activity to help the child's generalisation of talking.

When meeting the child, the dentist should assure them that there is no pressure for them to speak and they can communicate in whichever way feels comfortable for them. Children with SM like to know what is happening. Dental teams should talk through what will happen in the session with the parent/carer and child and use a visual timetable (pictures of each activity- e.g. talk to parent/child, look in mouth, special photo x-ray, clean teeth, sticker) to aid understanding for a young child or child with language difficulties.

Selective mutism often impacts a child's ability to ask for help or tell others if they are hurt or in pain and so this should also be considered when taking a history of presenting complaints. The use of a pictorial rating scale of pain can be used by the dentist to identify what the child feels can facilitate communication even if the child is verbal in a session. Children with SM can find it difficult to verbally express what they feel to strangers as this can be perceived as a high communication risk and more anxiety provoking. Other forms of non-verbal communication are important during treatment such as pre-agreed hand gestures (e.g. thumbs up for 'fine', thumbs down for 'not fine', hand up for 'stop'). Accepting the child's non-verbal forms of communication such as nodding and shaking of the head is extremely important when developing rapport in dental visits. The dental teams should try to keep the interaction fun and light-hearted and limit eye contact whilst speaking to the child will help them feel more at ease. The dentist should also try to relate topics to the child's interests (previously shared by parent). It is also important that the child is given enough time to respond (5 seconds) whether they communicate verbally or non-verbally. This type of interaction style is known defocused communication[5].

During rapport building, a fun activity can be helpful in creating joint attention (e.g. play or a game) using comments to take the focus off the child and limiting the use of questions in order to avoid putting pressure on the interaction. However, this is not always possible in a busy dental clinic. Therefore, rapport building comes from conversations with parent/carer and child through Johnson and Wintgen's question sequence based on communicative risk[2].

It is important for the clinician to ask questions directed at both of them and wait for five seconds. Parents should also allow time for the child to respond. If the child responds by speaking to their parent in front of the clinician, this is a good indicator that they are feeling more relaxed. It is crucial that the clinician does not show surprise or make a big deal out of the child speaking otherwise the child may stop due to attention being drawn to their speech. The dental team should not ask questions directly to the child unless they are speaking comfortably to the parent in front of others.

Once the child is feeling comfortable speaking in the session, the dentist should start with low risk questions (e.g. yes/no questions, 'Do you like to drink milk or water?'). If the child is answering those questions, then it is appropriate to move onto factual questions that can be answered by a phrase or short sentence (e.g. 'What are your favourite foods?'). If the child continues to answer these questions, then stepping up to subjective questions would be the next stage (e.g. 'Where are you feeling pain?', 'How much pain are you feeling?' with the pictorial rating scale for pain). If the child disengages and becomes silent, questions should be scaled down to allow for non-verbal responses.

Ensuring that the child is seeing the same clinician and nurse is also important in maintaining an environment that is familiar for the patient too. Finally, although there is no evidence to suggest that children with SM are more likely to have experienced abuse, trauma or neglect, it is important to be mindful that these children are less likely to make disclosures of abuse to professionals and in these cases, reliance on other indicators of abuse will be crucial in case of safeguarding concerns.

Conclusion

SM is an anxiety disorder that can cause profound disruption to the life of a child and their family. If untreated or inappropriately treated, it can continue into adulthood having a significant effect on education, relationships, employment, health and well-being. There has been much progress in the understanding of the nature and aetiology of SM but further research is required to improve identification and to increase awareness amongst education and health care professionals who work with children. Communicating with HCPs can be extremely difficult for children with SM. A sound understanding of the condition and being equipped with strategies to support the child could turn a potentially anxiety-provoking situation, such as a dental visit, into a positive experience. Whilst it is not in the remit of dentists to treat SM, we can ensure that our interactions do not reinforce the mutism and instead reinforce strategies that may already be being used as part of their therapy. In doing so, children with SM can access dental care in the same way as any other child.

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