Quality of Peer Relationships Among Children with Selective Mutism

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Abstract

The current study examined the quality of peer relationships among children with selective mutism. Previous research suggests that children who are selectively mute have difficulty making friends and have poor outcomes in treatment. Participants were derived from the UNLV Child School Refusal and Anxiety Disorders Clinic. An initial assessment was conducted by the Clinic therapist. The study utilized a demographic form, the Child Behavior Checklist, and the Anxiety Disorders Interview Schedule—Parent Version. The current study found that children who are selectively mute ranged in the quality of friendships, and this knowledge may be used to help treatment outcome.

Introduction

Selective Mutism

Selective mutism is classified as an anxiety disorder in the Diagnostic and Statistical Manual of Mental Disorders (fifth edition) (American Psychiatric Association, 2013). A critical feature of selective mutism is a consistent failure to speak in specific social situations. Failure to speak often occurs in school, despite speaking in other situations (APA, 2013). Failure to speak interferes with the individual's social, educational, or occupational functioning. Mutism must occur for at least one month. Mutism may not be caused by lack of familiarity of, or comfort with, the spoken language in a social situation.

Selective mutism occurs in 1.0 - 2.0% of children, and is reported more often in girls than boys. Female to male ratios have been reported at 2:1 (APA, 2013; Hayden, 1980; Wergeland, 1979; Wilkins, 1985). Selective mutism typically has an age of onset between 2.7-6.0 years (Black & Uhde, 1995; Cunningham, McHolm, Boyle, & Patel, 2004; Garcia, Freeman, Francis, Miller, & Leonard, 2004; Kristensen, 2000; Sharp, Sherman, & Gross, 2007; Steinhausen & Juzi, 1996). The most common location in which mutism occurs is the school environment (Black & Uhde, 1995; Dummit et al., 1997; Steinhausen & Juzi, 1996). The child may speak to parents at home and display fewer symptoms than at school (Edison et al., 2011; Schill, Kratochwill, & Gardner, 1996).

Mute behaviors can adversely affect social functioning and peer interactions (Sharkey & McNicholas, 2008). Positive peer relationships may play a vital role in the treatment of selective mutism. A child with selective mutism who speaks to one or two peers may be encouraged by those peers to speak to other people. Current literature is not sufficient on peer relationships in clinical samples. Therefore, the purpose of the current study is to examine the quality of peer relationships among children with selective mutism and explore the implications of positive peer relationships for effective treatment. The following section will briefly review anxious and oppositional symptoms in children with selective mutism and discuss their impact on peer relationships.

Anxiety and Opposition in Selective Mutism

Children with selective mutism often have a comorbid diagnosis of social anxiety disorder (Blum et al., 1998; Vecchio & Kearney, 2005). These children, therefore, may have difficulty making friends. Children with selective mutism often experience difficulties with social engagement and are behaviorally inhibited (Asendorf, 1993; Crozier, 1999; Kristensen & Torgersen, 2002). Children with behavioral inhibition may become quiet and withdraw in anxiety-inducing situations (Kagan, Reznick, & Snidman, 1987). Mutism may be a specific form of withdrawal and allows the child to avoid verbal interaction (Ford, Sladeczek, Carlson, & Kratochwill, 1998). A child with selective mutism may prefer being alone because speaking around other children may be too anxiety-provoking. Additionally, peers may not approach an anxious child with selective mutism because they may seem disinterested in play. Furthermore, children with selective mutism exhibit lower social competence than typically developing children (Cunningham et al., 2004; Cunningham, McHolm, & Boyle, 2006). Mutism often restricts involvement with other peers, and teasing by peers may occur (American Psychiatric Association, 2000; Giddan, Ross, Sechler, & Becker, 1997). Children with selective mutism have been reported to score significantly higher than population norms on the Child Behavior Checklist social problems scale (Achenbach, 1991; Achenbach & Rescorla, 2001; Steinhausen & Juzi, 1996). Risk for long-term problems with peer relationships and social adjustment may occur (Kolvin & Fundudis, 1981).

Defiant and oppositional characteristics also co-occur with selective mutism. Children with selective mutism have been reported as aggressive, disobedient, sulky, stubborn, negative, manipulative, suspicious, controlling, oppositional, and demanding (APA, 2013; Andersson & Thomsen, 1998; Brown & Lloyd, 1975; Hesselman, 1983; Kolvin & Fundudis, 1981; Kratochwill, 1981; Krohn, Weckstein, & Wright, 1992; Pustrom & Speers, 1964; Wergeland, 1979). Defiant and oppositional behaviors occur both at school and home for children with selective mutism.

Prognosis

Selective mutism is generally viewed as a persistent disorder with a poor outcome (Kolvin & Fundudis, 1981; Remschmidt, Poller, Herpertz-Dahlmann, Hennighausen, & Gutenbrunner, 2001; Steinhausen, Wachter, Laimböck, & Metzke, 2006).

Behavioral Therapy

Behavioral techniques are an essential component of intervention for selective mutism. Behavioral strategies aim to boost verbalizations, reduce anxiety, and reduce inappropriate attention seeking or oppositional behaviors (Cohan, Chavira, & Stein, 2006). Behavioral techniques utilize systematic desensitization, contingency management, verbal praise, video feed-forward, positive reinforcement, stimulus fading, shaping, unveiling a desired reward, self-modeling, and response initiation (Blum et al. 1998; Cohan, Price, & Stein, 2006; Kehle, Madaus, Baratta, & Bray, 1998; Krysanski, 2003). The goal of behavioral therapies is to remove reinforcement for mute behavior and reward verbal behavior (Krysanski, 2003).

Systematic desensitization involves learning to manage and overcome progressively more anxiety-provoking situations (Hung, Spencer, & Dronamraju, 2012). This type of therapy may be particularly effective for a child with selective mutism and may utilize peer interactions. Systematic desensitization may begin with a task meant to produce little anxiety for a child with selective mutism. Comfortable peers may offer support and encouragement to the child if they are feeling anxious or overwhelmed. An eventual treatment goal for a child with selective mutism may involve speaking comfortably with the child's teacher and peers in the classroom. The finding of positive peer interactions has implications for effective treatment. Specifically, peers that the child feels comfortable interacting with could aid in generalization of speech to other people and environments.

Hypotheses

Hypothesis 1 is that most children with selective mutism will be reported by their parents as having either zero or one friend. Children with selective mutism often do not speak in the classroom, and therefore, developing friendships may be difficult.

Hypothesis 2 is that children with selective mutism will be reported by their parents as displaying a range of anxious and oppositional behaviors. Specifically, children are hypothesized to not be liked by other children, be cruel or mean to others, get in many fights, physically attack people, be teased a lot, and be seen as too shy or timid, and withdrawn. These behaviors are expected to vary across children, and are hypothesized to hinder peer relationships.

Hypothesis 3 is that children with selective mutism will have trouble making friends, keeping friends and fear joining conversations as reported by their parents.

Methods

Participants

Participants (n=57) included youth with selective mutism assessed at the UNLV Child School Refusal and Anxiety Disorders Clinic aged 3-11 years. Participants were 59.6% female (n=34) and 40.4% male (n= 23). Youth were European American (45.6%), Hispanic (21.1%), multiracial/biracial (12.3%), Asian (10.5%), unreported or other (8.8) and African American (1.8%). Yearly family income was 0- $20,000 (1.7%), $21,000-$40,000 (22.4%), $41,000- $60,000 (22.4%), $61,000- $80,000 (8.6%), $81,000- $100,000 (6.9%), $100,000 or more (17.2), or not reported (20.7%). Parents were reported as married (62.1%), divorced (17.2%), separated (3.4%), or did not report their marital status (17.2%). Families had 1 additional child (38.6%), 2 additional children (26.3%), 3 additional children (8.7%) or 4 or more additional children (3.5%).

Measures

Demographic Form. Parents completed a demographic form to assess for child's gender, child's ethnicity, child's grade and age, educational information for father and mother, current marital status of the child's parents, family income, and gender and age of child's siblings.

Child Behavior Checklist (CBCL; Achenbach, & Rescorla, 2001). The CBCL is a 118-item rating scale used to measure externalizing and internalizing problems in children and adolescents aged 6-18 years. A form for children as young as age 4 years is also available. Both of these measures were used. A 3-point Likert-scale from "0" (not true) to "2" (very true or often true) is used by parents/guardians to rate their child's behavior. The CBCL contains several narrow-band scales: anxious/depressed, withdrawn/ depressed, aggressive behavior, social problems, thought problems, somatic complaints, attention problems, and rule-breaking behavior. Overall scores for Total Problems, Internalizing problems, Externalizing problems, and DSM-oriented scales are also provided. Items on the CBCL that capture peer relationships and peer interactions were used in the current study.

Anxiety Disorders Interview Schedule for DSM-IV--Parent and Child Versions (ADIS-C/P; Silverman and Albano, 1996). The ADIS-C/P is a diagnostic semi-structured interview that assesses symptom frequency, severity and duration of anxiety disorders in children. This study utilized only the parent version (ADIS-P). A parent-rated impairment level on a 9-point Likert-type scale (0-8) is included in the parent version. A score of 4 or greater indicates a clinically significant problem. The ADIS-C/P has good test-retest reliability (0.42-1.0; Silverman & Albano, 1996) and excellent interrater reliability (0.65-1.0). The measure follows DSM-IV guidelines for the major childhood disorders and has shown good construct validity (Langley, Bergman, & Piacentini, 2002; Tracey, Chorpita, Douban, & Barlow, 1997). The interpersonal relationships section of the ADIS-P was included in the current study.

Procedure

Participant data was obtained from the UNLV Child School Refusal and Anxiety Disorders Clinic. Data from families entering treatment in 2013-2014 and from past clients were included. Youth presenting to the Clinic are referred by counselors or school staff from Las Vegas and surrounding communities or are self-referred. The Clinic is a specialized setting to address anxiety disorders and school refusal behavior. Clinic therapists are clinical psychology doctoral students.

Initial assessments for youth and their families were conducted by the therapist. An initial assessment includes behavioral observations, parent behavioral measures, parent and youth structured interviews, and youth self-report measures.

Data analyses

A descriptive analysis was utilized via SPSS 21 to examine items pertaining to peer relationships on the Child Behavior Checklist (CBCL) and interpersonal relationships on the Anxiety Disorders Interview Schedule—Parent Version (ADIS-P). Results represent the number of parents endorsing that item for their child.

Results

Hypothesis 1

The first hypothesis was that children with selective mutism will be reported by their parents as having either zero or one friend. Children with selective mutism were found to have a range of close friends. Results are in Table 1.

Table 1.

Number of Close Friends

None	One	Two or Three	Four or More
15	13	19	3

Hypothesis 2

The second hypothesis was that children with selective mutism will be reported by their parents as not being liked by other children, to be cruel or mean to others, to get in many fights, physically attack people, be teased a lot, and be seen as too shy or timid, and withdrawn.

Children with selective mutism were more likely to be reported as too shy or timid, and withdrawn. As previously mentioned, children with selective mutism often have trouble engaging socially (Asendorf, 1993; Crozier, 1999; Kristensen & Torgersen, 2002). Additionally, social anxiety disorder is often comorbid with selective mutism and may cause a child to be shy and withdraw in social situations (Ford et al., 1998). Items such as cruelty, bullying or meanness to others, gets in many fights, and physically attacks people were not reported as occurring often. Therefore, these behaviors may be of less concern for children with selective mutism and may not greatly impact peer relationships. Additionally, children with selective mutism were not reported as not liked by other kids often. Children with selective mutism are reportedly liked by their peers even though they may not talk in their classroom. Results are in Table 2.

Table 2.

Descriptive Analysis on the CBCL

Items	Not true	Sometimes true	Very true
16. Cruelty, bullying or meanness to others	49	7	1
37. Gets in many fights	51	4	0
38. Gets teased a lot	40	11	4
48. Not liked by other kids	46	7	2
57. Physically attacks people	49	5	2
75. Too shy or timid	1	15	40
111. Withdrawn, doesn't get involved with others	19	17	21

Hypothesis 3

Hypothesis 3 is that children with selective mutism will have trouble making friends, keeping friends and fear joining conversations as reported by their parents. Hypothesis 3 was partly supported. Children with selective mutism were found to have difficulty making friends but were able to keep friendships once made. Additionally, fear of joining conversations was reported for almost all children. Children with selective mutism may struggle making friendships without the ability to initiate speech with another child. Results are in Table 3.

Table 3.

Interpersonal Difficulties

Item	Yes	No
Trouble making friends	39	12
Trouble keeping friends	9	39
Fear of Joining Conversations	48	3

Discussion

Previous research has reported that children with selective mutism may be rejected by their peers and experience few friends (Sharkey & McNicholas, 2008). However, findings from the current study support that children with selective mutism have a range of close friends, and also tend to get along with and are liked by other peers. However, support of interpersonal difficulties was reported. For example, children with selective mutism were found to have difficulty making friends, but were able to keep friends. One factor that likely plays a role in developing friendships is the child's difficulty joining conversations and speaking with those they are not comfortable. Speech is often necessary to get to know, share interests and feel comfortable around another person. Children with selective mutism may be limited in their ability to develop friendships and may need to rely on those they feel comfortable with to help make friendships.

Peer relationships may play a vital role in the treatment of selective mutism. The current study proposes that when treating children with selective mutism, it may be effective to already have a social network in which the child feels comfortable speaking. Children with selective mutism with positive peer relationships may receive encouragement from these peers to integrate into groups, start talking and make friendships. Ultimately, treatment can utilize the child's trusted peers to help generalize speech.

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