

**TREATING SELECTIVE MUTISM**  
*as a*  
**SPEECH-LANGUAGE  
PATHOLOGIST**

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# Preface

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As a high school student, my first job was teaching at a local preschool. I spent my days working on language, math, science, and social-emotional concepts with 2- to 5-year-olds, engaging in creative play, laughing at funny antics, watching friendships being formed, engaging in silly dances, singing catchy songs, and inventing elaborate dramatic play games. Throughout the years, I watched many children grow from toddlers to almost-kindergarteners in the program, and I watched as their personalities and skills continued to develop.

One year, I met “Caleb.” He entered our “Twos Turning Three” classroom and he didn’t speak a word. His mom reported that he had selective mutism (SM), an anxiety disorder that prevented him from speaking in most situations. He was able to speak to her at home, and sometimes in a whisper in other places, but that was it. Throughout the next 3 years, Caleb and I grew very close. I was so intrigued by this creative, funny, artistic little boy and determined to find ways for him to communicate with the people around him. We developed hand signals and used drawings and nonverbal communication and he slowly began to make friends, laugh silently at silly moments, and paint picture after picture at the easel, but he still was not able to speak at school. His speech-language pathologist (SLP) would come to school after the other students had left and work one-on-one with him in the classroom, helping him to get comfortable speaking there. After a few months of this, she invited me to be part of their sessions, so they could practice generalizing his speech to a new conversation partner. As we played “Hi Ho Cherrio,” she asked him, “Whose turn is it next?” and for the first time, I heard his voice as he said my name. I thought his SLP was magic. I was captivated by the work that she was doing with Caleb, how she was helping him to find his voice, and by the small steps forward we were starting to see. I wanted to learn how to help children like this, too.

I spent the next few years earning a BA and MA in applied developmental psychology, and then returning to graduate school for a

second time to earn my MS in speech-language pathology. I learned about anxiety and I learned about speech and language. I read everything I could about selective mutism and looked for chances to learn more. I found that the American Speech-Language-Hearing Association makes it clear that treating SM is within the SLP's scope of practice. I was able to find training programs and opportunities to work with children with SM at the Child Mind Institute and the SMart Center. I joined the Selective Mutism Association Board of Directors and became engaged in the work they were doing to promote awareness and provide resources for SM. And, children with SM began showing up on my speech therapy caseload at an elementary school. Suddenly, SM was everywhere—I was being invited to present on the topic at conferences and to graduate and undergraduate classes; it was becoming a topic of discussion and debate among teachers and SLPs on social media groups; parents were recognizing the signs in their children and looking for help and guidance, but finding that there were not enough trained professionals available to provide support and treatment.

Over the years, my experiences with these children and teenagers have been that they are an incredibly brave, resilient, creative, witty, kind, thoughtful, and wonderful group to work with, who simply need help finding their voice and practicing using it in new situations and with new people. As SLPs, our knowledge about treating pragmatic disorders and our understanding of how to elicit language in an intentional and scaffolded manner makes us prime candidates to work with these children and families. However, many SLPs hear that SM is an “anxiety disorder” and incorrectly conclude it is outside of their scope. This book is designed to dispel those myths, and to be a manual for SLPs who are looking for information about how to work with children with SM. It provides information regarding how to assess and treat children with this disorder using evidence-based practices and provides a number of resources for SLPs to utilize with their own clients. It is my hope that the information in this book will empower SLPs to use their knowledge and skills to help this group of children find their “brave voice.”

When Caleb was in second grade, I ran into him one weekend at a soccer tournament. He excitedly ran up to me and told me about the

game he had just won and his plans for the rest of the weekend. Gone was the hesitant whisper; he no longer avoided eye contact or turned away from interactions. I marveled at how easily and comfortably he was able to interact with me after so many years of silence, and how beautiful it was to see this version of himself and witness so much more of his personality, now that his words were no longer restricted by anxiety. Our work as SLPs can make all the difference for children like Caleb, by helping them to break out of their silence and share the true versions of themselves with the world around them.





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Thank you to Lily, Lucy, Connor, and their parents for being so willing to share their experiences. Your perspectives are so vital in helping others to have hope and to promote understanding of SM.

Finally, I am extraordinarily grateful to my team at Plural Publishing for reaching out to me with this initial opportunity and all the support and guidance they provided to me throughout this writing and publication process. I am so thrilled and thankful to have had this opportunity to write about this topic that is so near to my heart.



# Reviewers

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# Introduction

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*“When I had selective mutism it was really hard to talk to anyone besides my mom, dad, and sister. I couldn’t ask to go to the bathroom at school, tell a friend to stop bothering me, or ask the teacher for help. I couldn’t tell someone what my name was if they asked. I wanted to, but I couldn’t. It was like my lips were stuck together with superglue and the words couldn’t come out.” —Lily, age 13*

## Foundations of Social Language

Developing appropriate social language skills (also known as “pragmatics”) is crucial for building and maintaining meaningful relationships throughout the lifespan. As such, deficits in these skills can have extensive detrimental effects on a child’s mental health and social-emotional functioning, as well as their academic functioning. Speech-language pathologists (SLPs) are well-trained experts in the area of assessing and treating pragmatic language disorders. Therefore, it clearly falls within the SLP’s scope of practice to treat students who are experiencing difficulty engaging in social language tasks or interactions.

One group of children who exhibit difficulty in this area are children with selective mutism (SM). Selective mutism is an anxiety-based disorder in which the child is able to communicate appropriately in at least one setting (often, the home or with familiar family members) but is unable or struggles to communicate in other settings (i.e., school, community settings, etc.) or with other communication partners (i.e., peers, less familiar adults, teachers, community members, etc.). Children with SM may not demonstrate appropriate social language skills for a number of reasons. They may have had limited opportunities to develop and practice these skills, due to

avoidance of social interactions, or they may know when to use the skills (i.e., know when it's appropriate to greet a conversation partner) but be unable to do so due to their level of anxiety.

Social language skills can be divided into three primary categories of skills. The first skill is using language for different reasons, also known as “pragmatic functions.” This includes greetings and farewells, making requests for objects or actions, requesting continuation or cessation, providing comments or descriptions, making promises, and engaging in humor. Deficits in this area may look like omission of greetings and farewells, difficulty formulating questions to ask for things they want or need, difficulty knowing when and how to tell someone “no” or “stop,” difficulty providing detailed and meaningful explanations of things (i.e., retelling a story, making a comment about something in the environment), and difficulty telling or understanding jokes and teasing. Children may struggle with multiple pragmatic functions or may specifically struggle with one or two areas. A description of when various pragmatic functions develop can be found in Table 0–1.

The second primary social language skill is the ability to change language based on the listener. This includes altering the tone, register, length of utterance, and/or vocabulary used to talk to a younger child versus a peer or an adult. Another related skill is understanding the listener's perspective and being able to omit redundant information or add additional information in order to aid in the listener's understanding of the content. If the child is discussing the trip they took to the grocery store with the parent they went with, certain details are unnecessary because the parent was present in the shared experience and has the requisite background knowledge. If the child is explaining the trip to his grandmother, who was not there, he may need to add additional information such as where they were, who was with him, what they were doing, and so forth, in order to make his story meaningful and provide appropriate context. Also included in this skill set is the ability to modify language based on the situation. Children must be able to understand that how they talk to their friend on a playdate requires a different set of linguistic parameters than how they would talk to their teacher at school, whom they see regularly, versus their pediatrician, whom they see infrequently. Deficits in this

area typically manifest as difficulty interpreting the social situation and knowing what is appropriate (i.e., telling jokes in the middle of a religious service) or not being able to take the listener's perspective and therefore giving too much or too little background information. Additionally, it may look like engaging in "baby talk" at inappropriate times or difficulty shifting gears from more informal to formal conversations, such as knowing when to use polite versus more relaxed conversation, or knowing when to make direct requests ("Give me that blanket,") versus indirect requests ("It's really cold in here, I wish I had something to keep me warm.").

The final skill is following culturally appropriate rules for conversation. This includes allowing appropriate turn-taking with the conversation partner, initiating conversations appropriately (i.e., getting the partner's attention appropriately, informing partner of the topic to be discussed), maintaining the topic throughout the conversation, revising and repeating language to clarify when the meaning was misunderstood by the listener, utilizing and understanding nonverbal language (i.e., gestures, facial expressions, eye contact), demonstrating awareness of appropriate personal space, and using and understanding how tone of voice affects the message and intent. Deficits in this area may look like children who monopolize conversations and do not allow time and opportunities for others to talk, or who continually draw the topic back to preferred topics instead of shifting topics with the partner. It can also look like difficulty using or understanding nonverbal language, including not noticing or interpreting it at all and therefore missing cues such as when a partner wants to end a conversation or when they are uninterested versus invested in the topic. Additionally, children with deficits in this area may have difficulty maintaining appropriate personal space (ASHA, n.d.).

Social language begins to develop as early as the newborn to 3 months stage, when infants engage in turn-taking with caregivers through smiling and cooing, attending to eyes and mouths, and demonstrating preferences for faces (Peters, n.d.). From there, social language continues to develop and be refined through adolescence (see Table 0-1).

Clearly, children are working hard to develop a variety of skills throughout both the early and later childhood years. Developing these

skills and continuing to practice them across a variety of situations and with a variety of communication partners is crucial in the refinement of these skills and to the success of social interactions. Children who cannot practice these skills or do not have the opportunity to do so are at a significant disadvantage compared to their peers, and with every instance of avoiding practice, fall further and further behind in development of appropriate social language skills. Therefore, it is critical for SLPs to identify children who have difficulty with social language skills and provide appropriate intervention as early as possible, in order to ameliorate current deficits and avert potential negative long-term consequences.

Students with SM are at particular risk for these negative long-term consequences. However, research is clear that children with SM who receive appropriate treatment can and do make significant progress, and can go on to form strong, meaningful friendships; participate and be contributing members of teams and groups; assert and defend their opinions appropriately; and demonstrate all other age-appropriate social language skills. Students with this disorder require intervention that integrates components of cognitive-behavioral therapy geared towards treating anxiety disorders coupled with the knowledge of language development and complexity that SLPs possess. As such, with a little training, SLPs are in a unique position to serve as members of a treatment team and provide vital, life-changing intervention to these students who so desperately need it.

The purpose of this book is to provide adequate background information regarding anxiety disorders, specifically SM; information about diagnosis and assessment of children with SM; and a clear overview, with examples, strategies, and ideas, of how to provide evidence-based treatment for children with selective mutism. Ideally, this book can serve as a manual for SLPs working with students with SM and enable them to make a tremendous difference in the lives of children who desperately want to use their voice effectively.

*“I am really happy that I can use my voice in all settings now. I can stand up for myself and talk to my friends just like all the other kids.” —Lily, age 13*



**Table 0–1. Development of Social Language Skills**

0–3 months	Smiles/coos responsively Attends to eyes/mouth; shows preference for faces Demonstrates turn-taking
3–6 months	Laughs during social interactions Maintains appropriate eye contact Takes turns with vocalizing Follows gaze of communication partner Mimics facial expressions
6–9 months	Vocalizes to get attention Demonstrates attachment Shows self in “Peek-a-boo” Reaches/points to request
9–12 months	Begins directing others Participates in verbal routines Repeats actions that others laugh at Tries to restart play Uses play routines (give and take, build and knock over) Pragmatic functions (vocalizations/gestures): protest/ reject, request objects or action, call, express feelings, notice/comment, respond to others, and refuse
12–18 months	Imitates routines Imitates older children Pragmatic functions (words): protest/reject, greet/call, respond to others, label/comment, request objects/ actions, express feelings/wants Controls behavior of self and others Responds to adult conversational attempts Pragmatic functions closer to 18 months (words): request information, initiate pretend play, comment/tell information, acknowledge/answer
18–24 months	Pragmatic functions (2–3 words): protest/reject, greet/ call, respond to others, label/comment, request object/ action, express feelings, request information, initiate pretend play, tell information, acknowledge/answer Practices familiar conversational routines (book-reading, going to restaurant, etc.)

*continues*

**Table 0–1.** *continued*

24–30 months	Uses “please” for requests Engages in symbolic play Able to talk about absent objects Misrepresents reality (lies, teases) Narratives comprised of labels and descriptions Announces intentions Engages in conversations of two turns each Introduces and changes topics Verbally expresses emotions Begins to give descriptions to aid listener’s understanding Clarifies by repeating Requests clarification
30–36 months	Speaks in sentences Attempts to control situations verbally Uses polite “nice” intonation patterns Responds to requests to clarify Apologizes with “I’m sorry” Able to maintain topics ~50% of the time Maintains topics by adding new information Increases use of language in play Narratives begin to include sequences with theme but no plot Understands that others can want different things
36–42 months	Engages in/maintains conversation of 4–5 conversational turns each Uses filler words to acknowledge Begins to shift tone with younger children Makes choices Requests permission Uses language for teasing/jokes/fantasy Consistently uses descriptions to clarify; gives description of objects wanted Expresses specific personal needs Requests help

**Table 0–1.** *continued*

36–42 months <i>continued</i>	States problems Corrects others Uses pronouns Gives directions to play a game or make something Identifies and explains feelings (“I’m sad because it broke.”) Provides excuses or reasons Offers an opinion with support Complains Blames others Disagrees with others Compliments others Can provide personal information (name, age, address, birthday, etc.) Uses appropriate social rules for greetings, farewells, getting attention Requests through yes/no questions Asks questions out of curiosity Begins to role play as different characters Makes polite requests; uses permission directives (“Can you . . . ?”) and indirect requests (“Would you . . . ?”) Less direct requests and more indirect requests Narratives have theme and some temporal organization
42–48 months	Has long, detailed conversations Initiates a topic of conversation (vs. starting to talk in the middle) Tells two events in correct order Tells story mixing real and unreal components Uses pronouns across sentences New pragmatic functions: reporting on past events, reasoning, predicting, expressing empathy, creating imaginary roles and props, and maintaining interactions Understands that others can have different beliefs

*continues*

**Table 0–1.** *continued*

4–5 years	<p>Uses hints that do not mention the intention in the request</p> <p>Increased ability to address specific requests for clarification</p> <p>Correctly uses and changes references terms this/that, here/there, go/come</p> <p>Uses this/that/these/those from listener’s perspective</p> <p>Initiates easily</p> <p>Ends conversations (may be abrupt)</p> <p>Changes topics appropriately</p> <p>Uses apposition to cue the listener</p> <p>Revises/repairs an incomplete message</p> <p>Interjects appropriately into established conversations with others</p> <p>Apologizes and/or explains behavior</p> <p>Requests clarification</p> <p>Criticizes others</p> <p>Asks questions to systematically gather information (i.e., 20 questions)</p> <p>Explains relationship between two objects, actions, or situations</p> <p>Correctly retells a story that was told to them</p> <p>May begin to tell lies</p> <p>Expresses humor/sarcasm</p> <p>Original narratives are “chains” with some plot but no high point or resolution</p> <p>Understands that he/she can know something that others don’t know</p>
5–6 years	<p>Uses focused chains for narratives</p> <p>Gives threats/insults</p> <p>Issues promises</p> <p>May give praise</p> <p>Maintains topic of conversation for 10 turns each</p> <p>Self-monitors speech for errors</p> <p>Engages in negotiations (play roles, turns, ending of play)</p>

**Table 0–1.** *continued*

5–6 years <i>continued</i>	Understands that a person can feel something but may not demonstrate it (“hidden emotions”)
6–8 years	Can give multiple-step directions Creates well-formed narrative Uses multiple-sentence descriptive language (creates riddles, describes characters) Makes and responds appropriately to evaluative comments/corrections Checks listener’s comprehension Produces full explanations Responds appropriately to compliments Apologizes and responds to apologies appropriately
8–9 years	Uses language to establish and maintain social status Demonstrates increased perspective-taking, more successful persuasion Provides conversational repairs by defining terms or giving background information Begins to understand jokes and riddles based on sound similarity
9–12 years	Narratives include complex, embedded, interactive episodes Understands jokes and riddles based on lexical ambiguity
12–14 years	Uses expository texts in school-based writing Most academic information is presented in expository format Understands jokes and riddles based on deep structure ambiguity
14–18 years	Language is used to maintain social bonds Persuasive and argumentative skills reach near-adult levels

Source: Adapted from Peters (n.d.) and Goberis (1999).



# 1 Overview of Anxiety

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Fear is a normal, healthy response to threatening stimuli. All humans experience fear, and fear serves an adaptive purpose. From an evolutionary perspective, fear serves the purpose of stopping us from entering dangerous environments and preventing us from engaging in unsafe activities.

When a person is confronted by a fear-evoking stimulus, a complex neurobiological response, including a cascading physiological and hormonal process, is initiated in the brain. First, the eyes and/or ears communicate the information about the stimulus to the amygdala, the part of the brain responsible for managing emotional responses and processing, specifically fear and anger. When the amygdala receives the signal, it triggers a second signal, alerting the hypothalamus of the danger. The hypothalamus is often known as the “control center” of the brain, as the signals that travel to the rest of the body’s nervous system are usually directed through the hypothalamus. The hypothalamus is responsible for regulating the body’s autonomic nervous system, which is comprised of the sympathetic and parasympathetic nervous systems. The autonomic nervous system governs the operation of many involuntary bodily functions, including respiration, heart rate and blood pressure, and the dilation or constriction of airways in the lungs. When the hypothalamus receives the “danger” signal from the amygdala, it activates the sympathetic nervous system. This, in turn, triggers the fight, flight, or freeze response. The signal passes through the adrenal glands which release a burst of epinephrine (also known as adrenaline), so that the body is equipped to handle the dangerous situation. Epinephrine

triggers responses throughout the body, including increasing heart rate; directing blood flow to muscles, heart, and vital organs; increasing pulse rate and blood pressure; and opening up airways in the lungs to allow for the person to breathe heavily. This allows more oxygen to be sent to the brain which in turn increases the brain's level of alertness to the dangerous stimulus. Additionally, the senses of sight and hearing are enhanced. This initial activation of the sympathetic nervous system happens so rapidly that people are not aware of it; in fact, the entire cascade effect is triggered and complete before the brain is able to fully process what the dangerous stimulus is (Harvard Health Publishing, 2018).

Fear responses can usually be categorized into one of three types, and are colloquially referred to as “fight, flight, or freeze.” “Fight” responses can be seen in nature in the form of animals that engage in an altercation to protect themselves or their offspring from a dangerous stimulus. In modern-day human society, a “fight” response can manifest as physical or verbal aggression, such as a desire to hit, rip, or punch something; a desire to stomp or kick; a clenched jaw or fists; grinding teeth; feelings of anger or rage; and using metaphors that indicate aggression, such as talking about bombs or erupting volcanoes. In extreme circumstances the individual may also experience homicidal or suicidal feelings. However, the “fight” response can also manifest as less obvious symptoms. Anxious people experiencing a “fight” response may demonstrate crying, tense or flexed muscles throughout the body, and/or a “knotted” or burning stomach feeling or nausea.

“Flight” responses get their name from animals in the wild that flee the dangerous situation in order to maintain safety. In some cases, the “flight” responses in humans may look similar—people may attempt to leave the situation that is triggering their fear, whether it is getting away from a certain person, getting out of a certain environment, or actually running away from the dangerous stimulus. Less obvious signs of a “flight” response include feelings of restlessness or numbness in the feet or legs; shallow breathing; enlarged pupils; fidgety movements, especially of the legs and feet; feelings of being trapped or tense; or the need to engage in excessive exercise.



The “freeze” response originates from animals in nature who become motionless when confronted by danger in an attempt to be unnoticed, so that the dangerous stimulus will pass by. People experiencing a “freeze” response may physically or mentally “freeze” in place and have difficulty moving or thinking about ways to manage the situation. They may also report feeling “stuck” in some part of their body; feeling cold or numb; having paleness of skin; holding their breath or experiencing restricted breathing; feeling a sense of dread; feeling their heart pounding; and/or a decreased or increased heart rate (Trauma Recovery, 2013).

After the initial burst of epinephrine, which triggers the flight, flight, or freeze response, the hypothalamus activates the pituitary glands in addition to the adrenal glands. Together, these three structures (known as the HPA axis) continue to keep the sympathetic nervous system activated. If the source of danger is still present, the hypothalamus and pituitary glands continue to release hormones, which in turn trigger the adrenal glands to release cortisol. Cortisol keeps the physiological alertness of the body intact until the threat has been managed or is no longer present. At this point, the parasympathetic nervous system is activated in order to subdue the stress response (Harvard Health Publishing, 2018).

However, fear can become overactive and can signal an emergency at inappropriate times. Fear can be triggered not only by an immediate event but also by one’s thoughts about a future or past event, which is often referred to as “anxiety.” Just like fear, some level of anxiety is normal and important for appropriate everyday functioning. However, when anxiety becomes too frequent, lasts for too long, or is impairing one’s ability to complete everyday tasks, this signifies that an anxiety disorder may be present.

The *Diagnostic and Statistical Manual, 5th edition* (DSM-5; American Psychiatric Association, 2013) categorizes many disorders under the heading of “anxiety disorders.” These include social phobia, generalized anxiety disorder, specific phobias, separation anxiety, selective mutism, and others. Anxiety disorders are incredibly prevalent in the worldwide population, with recent estimates suggesting that as many as 1 in 5 individuals experience anxiety disorders

at some point in their lives (Kessler et al., 2009; Whiteford, Ferrari, Degenhardt, Feigin, & Vos, 2015; Wittchen et al., 2011).

Treatment methods for anxiety disorders span a large spectrum of options. This includes psychological interventions, such as cognitive-behavior therapy, psychoanalysis, supportive counseling, brief psychotherapy, and group psychotherapy (Mangolini, Andrade, Lotufo-Neto, & Wang, 2019). For social anxiety/phobia, and selective mutism specifically, evidence-based treatment methods include social skills training, relaxation, exposure-based methods, cognitive behavioral therapy, group therapy, and systematic desensitization (Chambless & Ollendick, 2001; Nathan & Gorman, 2002). Additionally, in place of or in addition to psychological interventions, pharmacological interventions may be used. These include antidepressants, bupirone, benzodiazepines, beta-blockers, and in some cases, anti-psychotic medication (Mangolini et al., 2019). Furthermore, some clients may choose to supplement these interventions with alternative therapies such as aromatherapy, acupuncture, exercise, herbal medicine, homeopathy, massage therapy, mindfulness, yoga, and other relaxation techniques. A review of these treatment methods indicates that while many clinicians are supportive of these therapies in a supplemental role, there is not enough evidence to suggest that alternative therapies alone are effective at managing anxiety disorders (Craske, Stein, & Hermann, 2016).

Throughout this book, the term “clinician” is used to refer to a treatment provider, which may include a psychologist, social worker, or speech language pathologist (SLP). In cases where more specific aspects of a treatment provider’s work or scope of practice is being discussed, the provider’s title (i.e., psychologist) is used. In many cases, there may be more than one type of clinician working with the child and family. Clinicians, doctors, parents, and children must work together to determine the most effective treatment methods for their individual needs and situation. In many cases, it may take a trial-and-error process with more than one treatment technique before the right one is discovered and implemented. At the same time, it is important to give each treatment method a reasonable amount of time to work, to determine if there is improvement in the child’s skills or lessening of their anxiety symptoms.

It is important to have an understanding of anxiety and the responses that it can cause, as selective mutism (SM) is an anxiety disorder at its core. However, it is a unique disorder that requires collaboration from multiple fields (i.e., psychology, psychiatry, and speech-language pathology, etc.) because the effects of the anxiety can be seen in the child's social language skills and abilities—an area that is within the SLP's scope of practice. It is critical that treatment teams address both the underlying anxiety component of the disorder (i.e., through medication, therapy, or both) as well as work on teaching the child appropriate social language skills and providing many opportunities to practice using these skills across multiple people, places, and activities. Additionally, understanding the etiological factors that contribute to the development and maintenance of SM can help the team decide how to progress with treatment. The next chapter includes an overview of the history of SM and etiological factors.