PSYCHOTERAPIA 1 (196) 2021
strony: 33–47
DOI: 10.12740/PT/132249

Angelika Listwan[1], Artur Kołakowski[2]

COGNITIVE-BEHAVIOURAL THERAPY OF A PATIENT WITH SELECTIVE MUTISM – CASE STUDY

[1]Sentio psychological office
[2]Team of psychotherapeutic offices Beyond Schemas

selective mutism
social phobia
anxiety

Summary

The presented article has two main aims. Firstly, the presentation of the current way of understanding selective mutism (SM), and secondly, — the description of a patient's therapy based on the cognitive-behavioural model. The main symptom of SM is selectivity of speaking, which applies to specific environments or people. The way selective mutism is classified and treated has been changing in recent years. What is more, researchers dealing with SM have still not established a coherent model of development and persistence of this disorder.

In the DSM-5 classification, selective mutism has been moved from the category "disorders of childhood and adolescence" to the subsection of anxiety disorders. The main aim of the implemented change was to emphasize the leading role of fear in the development and persistence of SM. Cognitive-behavioural therapy of mutism is perceived as treatment of choice and to a great extent is related to overcoming a child's fear of speaking. Because of a limited number of studies, models of therapy based on case reports, and the diversity of clinical pictures, the psychotherapist must adjust the standard model of cognitive-behavioural therapy to a particular patient.

Because of the fact that most research is based on case studies, there is a great need for both research on a larger scale and for testing the efficacy of psychotherapy. Currently, the access to qualified therapists is very limited, and the low consciousness of the need for help (especially for children) definitely needs to be changed.

Introduction

Selective mutism (SM) is a disorder which causes, the type of classification and treatment are not homogenous. There is no coherent conception of this disorder despite research that has been carried out among children and adolescents. In the latest DSM-V classification, selective mutism was categorized as an anxiety disorder, as opposed to the previous categorization – childhood and adolescence disorder [1]. Selective mutism appears quite

rarely, in about 1% of patients, more often during childhood, among girls and bilingual people [2]. Treatment and psychotherapy of patients with selective mutism is a challenge for therapists, teachers and carers of people who suffer from this disorder.

It should be stressed that there has been a change concerning the age of the patients who may be diagnosed with selective mutism. Consequently, both children and adults can suffer from this condition.

Evolution of the selective mutism's classification

Selective mutism was classified for the first time in 1877 by Adolf Kussmaul, who introduced the term *aphasia voluntaria* and described patients who did not speak in certain situations [3]. Later, in 1934, there has been a change in the name of disorder: it was called *elective mutism* (EM). Researchers underlined the main role of the patients' willingness not to communicate, despite their linguistic skills.

In the DSM-IV classification the name of *elective mutism* has been changed to *selective mutism*. The word *selective* underlined the essence of this disorder – lack of communication in certain situations because of the anxiety, unlike the previous term which stressed an intentional refusal of conversation identified with a conscious manipulation [1].

To diagnose SM [4] three criteria must be fulfilled:

a) the correct or close to correct level of understanding the speech,
b) speech competence sufficient for social communication,
c) clear proofs that a child can speak in certain situations normally or almost normally.

In the new ICD-11 classification, selective mutism was categorized as an anxiety disorder, as it was done in DSM-V. There is a strong emphasis on the constant selectivity in the process of communication, in which a child has speaking abilities in different social situations, mainly in home environment, but refuses to speak in other places, usually at school. To diagnose this disorder, it must last for at least a month, it cannot be constricted to the first month of school education, and definitely has to impair not only individual's educational improvements, but also social communication and professional achievements [5].

Clinical picture of selective mutism

Communication difficulties with other people among patients suffering from SM are very diversified – from a complete lack of communication in almost every situation to a cease of using spoken language in certain situations and with few people. The place where symptoms of selective mutism appear the most frequently is school. A child suffering from SM does not communicate or communicate in a very limited way with a teacher

[6]. A child diagnosed with mutism may sometimes only talk to chosen friends; however, there might be a situation with no communication at all. A patient usually communicates with close relatives, but in literature there are described clinical cases of children who speak at school, but remain silent at home [7].

Review of the literature shows that symptoms of selective mutism appear at age group from 2.7 to 4 [8]. Symptoms of the disorder are usually visible for the environment when a child starts school education, which can be explained by the growth of social demands and need to talk to teachers during lessons. As a result, it causes an intensification of symptoms [9]. The long period between appearance of selective mutism symptoms and diagnose may be probably explained by the fact that a child communicates with close relatives without any difficulties and parents do not notice the problem. There is also a greater consent for children's shyness during the preschool period.

Mutism etiology

The causes of selective mutism are still not well known. In recent years many authors emphasize the multifactorial etiology of this disorder and the role of a vulnerability–stress model [10]. In the clinical approach, there must be mentioned the role of inheritance (inborn vulnerability), factors that trigger and sustain this disorder. The research of 38 children shows that there is a great intensity of a trait such as taciturnity in the first, second and third generation of selective mutism patients' relatives. This fact shows a great importance of the family background for the appearance and maintenance of this disorder [11]. The next factor that increases the person's vulnerability to suffer from selective mutism is temperament [10] and behavioral inhibition, described as anxiety reactivity to new stimuli.

The most obvious and often proposed explanation of subtle or more visible deficits in the mutism etiology is avoidance [10]. A child starts to avoid speaking, because is not able to keep up with the environment's demands (for example parents, teachers).

Moreover, the previously mentioned research concerning triggering factors of selective mutism did not result in explicit results. Researchers emphasize that the experience of trauma or other difficult life events may cause the symptoms. The data is retrospective, so it is not possible to control it fully and it does not bring convincing conclusions concerning connection between possible factors causing mutism [12–14]. The other research shows that parents of mutistic children perceive them as withdrawn, and admit that symptoms became visible when they attend kindergarten [15]. During that time, a child is forced to talk to new people, which in combination with aforementioned behavioral inhibition may be recognized as the most probable triggering factor SM [15].

Earlier research and clinical observations show that there is no clear difference between etiological and triggering factors of SM. Researchers focus on finding factors

connected with sustaining symptoms. It would help to modify therapeutic interventions. It is necessary to distinguish four factors that sustain selective mutism: child's avoidance of speech, the way other people talk to a child, the lack of balance between forcing a child to a conversation and accepting his/her silence, and implementing the strategy: 'wait and observe'.

Scott and Beidel suggest that mutism is a way of intensive emotions' regulation [16], that guarantees effective avoidance. The Young and associates' research show especially intriguing results [17]. During the assessment of skin-galvanic reaction, children with SM showed lower psychophysical arousal than children suffering from SAD (seasonal affective disorder), which would confirm the hypothesis of mutism as a strategy of avoidance. Children in the focus of attention experience a very high level of anxiety and retreat from the conversation ("I can't start talking, because teachers will talk about my talking" – patient's report).

As aforementioned, the part of research indicates the excessive parents' control among families of children with mutism [17]. It may be a kind of parent's monologue, not a dialogue with a child, which as a result causes lack of motivation to talk independently. This phenomenon affects not only parents, but also teachers and peers who tend to make conversation and do things for them. Forcing a child to speak is another obstacle in the SM treatment. Parents try to encourage their child to start conversation by offering them rewards. The same behavior takes place among teachers who additionally give punishments for the lack of answers to their questions. Last but not least, the strategy: "wait and observe" or ,"he/she is going to grow out of it", is also frequently used by families of children with

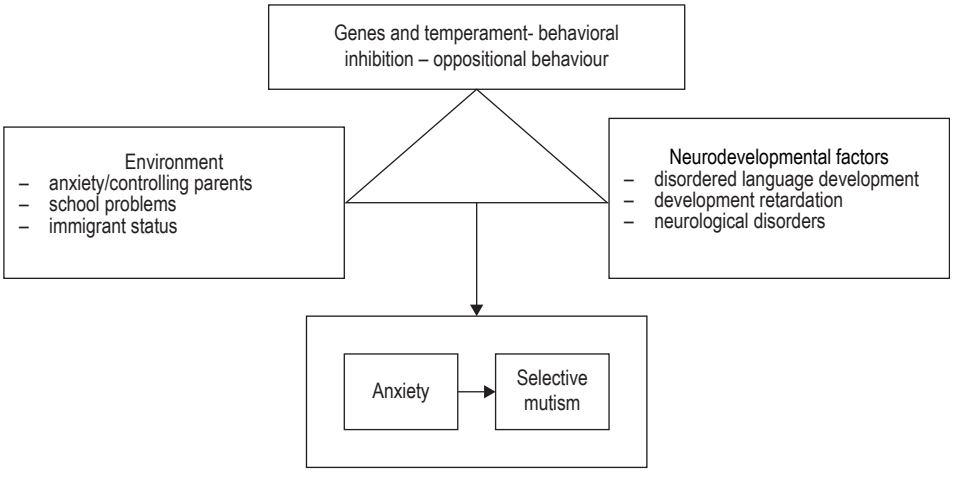

Figure 1. **Mutism etiology (own elaboration)**

SM and teachers, which consequently sustains communication difficulties. Drawing No 1 shows the selective mutism's complex etiology.

Mutism epidemiology

Mutism is described as a state which appears mainly among children, but it may be also recognized among adults, but in this older group symptoms are more often categorized as social anxiety disorder [9] or other anxiety disorders. Selective mutism is more common among girls than boys and differs in frequency in a proportion from 2,6:1 to1,5:1 [9].

Numerous long-term studies of mutism show very high differentiation of symptoms' duration – from few months to years. In description of SM patients' traits, the most popular are the following: shyness, social anxiety disorder [9], low self-esteem, low confidence, lower number of achievements in comparison to healthy children and lower social communication abilities during adolescence and adultery [7, 18].

Apart from anxiety, selective mutism patients also suffer from symptoms/comorbid disorders, such as: communication and language disorders [13, 19], obsessive-compulsive disorders [20], fragile X syndrome [7], attention deficit hyperactivity disorder (ADHD) [21], depression, panic attacks, dissociative disorders and other somatic complaints [9].

Mutism treatment

In the last decades the number of described interventions in randomized, controlled, clinical research (RCTs) concerning anxiety disorders among children significantly surged [22]. For the most of latest research authors, mutism is described as a disorder difficult to treat. Literature concerning the therapy of SM is dominated by the case study descriptions. Different interventions present heterogeneity in theoretical orientation of therapist and disorder conceptualisation from psychoanalytical plan of therapy, systemic therapy, to behavioral and behavioral-cognitive interventions. Together with the change of mutism's concept as an anxiety disorder, there is a growth in number of behavioral and cognitive approaches in children treatment observed. Over the period 2005-2015, the number of research using behavioral and cognitive techniques has risen by 100% [23]. In one of the recent overviews (2017), most of the research joined two approaches, for example cognitive and systemic. According to the systemic therapy assumptions of selective mutism, parental neurotic control generates excessive attachment between a child and a parent. As a result, it causes dependence in a child-parent relation and lack of trust towards non-family environment. Anxiety rises, also concerning social communication, which causes muteness [24].

Among the most commonly (90.5% of the reviewed research) introduced behavioral strategies were: positive reinforcement, modeling (57%), exposition (47.6%) and curbing fearful stimuli (42.9%) [14]. Social Communication Anxiety Treatment (S-CAT) is an example of an efficient therapeutic program [25]. Children taking part in this program showed a significant change in communication. Moreover, the reduction of selective mutism symptoms was observed. To conclude, there are some differences in implemented interventions concerning children with diagnosed SM, but most of them have the same main assumptions such as: positive therapeutic relation establishment before exposition, positive reinforcements in different situations, involvement from parents and teachers (figure 2.)

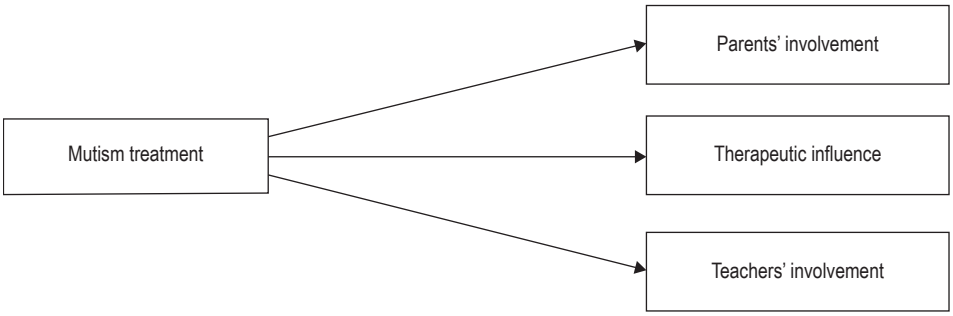

Figure 2. **Different forms of mutism treatment (own elaboration)**

Considering the subject of pharmacotherapy efficacy in children's selective mutism treatment, it may be stated that it brings positive effects [26]. The first research concerning medicines' efficacy lasted 10 years. Among children who were treated with SSRIs there was observed a great symptoms' decrease (81% of patients). The mechanism concerning SSRIs efficacy is still unknown. Surprisingly, the research conducted among children with SAD without SM showed that while the behavioral-cognitive approach prepared for SAD caused the social competence growth, pharmacotherapy mainly lowered the level of anxiety 27]. The aforementioned results, confirm potential value of combining medical and psychological approaches, especially among older children with SM (over 7 years old).

Description of a therapeutic plan

The girl's therapy plan was based on the of interventions discussed in the literature and dr Elisa Shipon-Blum's guidelines, the head director of the Smart Center, which aims at treating mutism and other anxiety disorders in the USA. The aforementioned researcher, developed the concept of treating anxiety disorder, including mutism, called Social Communication Anxiety Treatment (S-CAT). The S-CAT program is suitable for children, teenagers and adults with selective mutism, social anxiety, extreme shyness and other difficulties related to social communication. S-CAT is based on the concept that mutism stems for the anxiety disorder connected with social communication and goes beyond the lack of speech only. The aforementioned method integrates not only the components of cognitive and analytic therapy but also the approach oriented on the insight, so as to increase the possibility of social communication emergence and to promote social trust [29].

The developed therapeutic plan aimed at the child's realization of the next stages of social communication according to S-CAT method with regard to own modification of the therapist. The first of them (stage 0), might be defined as non-communicative. On this stage, the child does not answer to the messages from other people and initiate them, but also behaves as 'frozen' and ignores someone's presence. The first stage (nonverbal) assumes that the patient presents diverse nonverbal actions such as nodding, pointing, gesturing and writing. However, on the second stage, named transitional period, a child starts to use sounds to communicate, increases the frequency of verbal answers in the form of simple, single words. The final stage lays the emphasis on the child's verbal response (whisper, silent conversation, reading aloud, change in the tone of voice) [29]. It ought to be highlighted that the basic prerequisite of discussed components of the therapy is establishing a safe relation with a child. Initial meetings (before the realization of stages 0-3) should be based on creating child's acceptance towards a therapist and their mutual trust.

Case presentation

The patient, 11 years old girl, born in the 39th week of pregnancy was given 10 points in the Apgar scale. Her psychomotor development and language system proceeded without any retardations. In the time of pre-school education, the patient communicated with her relatives freely; nevertheless, she never spoke to her peers or the supervising teacher. During the last year of her education there, she got acquainted with a girl, who was very courageous and often did things for her in various activities proposed by the teacher such as cooperation with children or oral presentations. According to the symptoms which

were discussed retrospectively by her parents, the girl complied with the requirements of selective mutism in ICD-10 and DSM-5.

The exacerbation of symptoms of selective mutism might have been observed since the beginning of her education. It could be caused by the new school environment or change of the place where the lessons took place. Furthermore, according to the parents and girl's opinion, during that time, the head teacher of the class used to humiliate children and treat them inequitably. Based on the parents' report, the girl displayed a high level of fear in the first grade, intensified even more by accumulating difficulties with learning. Consequently, the parents decided to diagnose girl's problems with communication and consult her in the psychological – pedagogical counselling centre. In relation to the psychological study carried out at the age of 8, it was stated that her mental development is substandard. The fact that, in the parents' view, the girl wasn't willing to cooperate during the study and easily abandoned cerebration was certainly not without significance. Thus, meetings with a psychologist, scheduled after the examination did not bring anticipated results. The psychologist who conducted therapy, claimed that treatment is pointless unless the girl is willing to cooperate. As a result, parents of the girl decided to wait with beginning of another therapy until the girl starts to speak on her own.

There was no change in the girl's speech development and communication until the age of 11. The patient did not communicate verbally with her teachers and during new social situations, i.e., a holiday trip. She made conversation with most of her peers during breaks only. Concerned by this situation, parents decided to consult that case again with a psychologist and a psychiatrist. Pharmacotherapy in the form of SSRI was implemented.

Currently, the girl attends the 5th class of a state primary school in a small town, achieves low results in education and performs low motivation in undertaking cerebration. The patient lives with her parents and an older sister with whom she has adequate relations. Her parents are professionally active. The mother is a nurse and works shifts; her father is a taxi driver. Both of them were shy and withdrawn during the childhood so they understand problems of their daughter.

The individual conceptualization of the patient based on a few months of therapy is presented below (Figure 3).

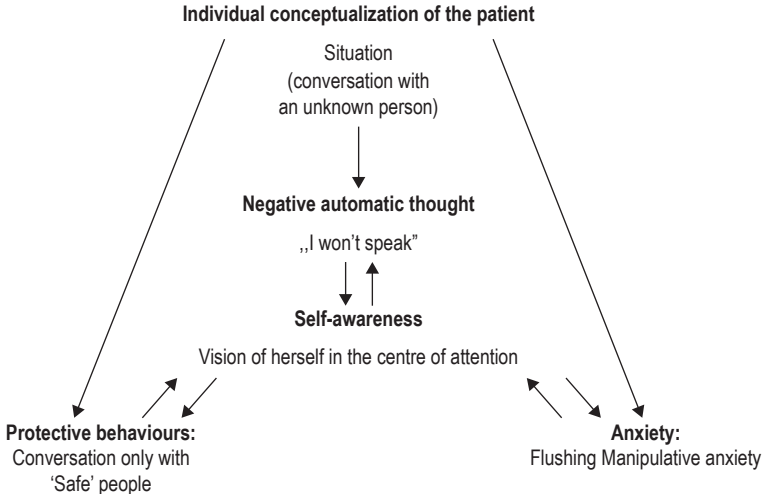

Figure 3. **The patient's conceptualization. Own elaboration**

In relation to the analysis of girl's behavior, there were distinguished typical automatic thoughts, emotions and behaviors in problematic situations connected with social communication (Table 1.).

Table 1. **Typical automatic thoughts, emotions and patient's behavior (own elaboration)**

Situation	Automatic thoughts	Emotions	Behavior
Reading the instruction in the class	I am weak Everybody looks at me	anxiety sadness	patient does not speak at all
Conversation with a teacher	I am not able to say anything again The others will notice that I am afraid	anxiety sadness irritation	patient shrugs

Meetings with the girl enabled to establish her hypothetical key beliefs concerning herself, the world and other people, she had contact with (table 2). Regarding her intermediary beliefs, which could maintain her high level of anxiety, it could be stated that there are two dominant ways of thinking: „ If the others hear what I say, they surely judge me negatively and think I am weird". „ If I cannot cope with such an easy thing as speaking, I am too weak".

Table 2. **The key beliefs concerning herself, world and other people.**

I	World	Others
I am weak	It is threatening	they check and judge me constantly I can't trust them

Therapy description

Because of the girl's disorder specificity, the following therapeutic process was elongated and lasted many sessions before the effects were visible. What is more, it required high flexibility during sessions because the patient was not always eager to cooperate. The girl was slowly establishing a therapeutic relation with therapist, which required a lot of care during implementation of new steps. Girl's cheerful mood and her willingness to take part in activities, which were not accepted by her before, were definitely helpful. The most challenging were sessions during which the patient refused cooperation, as some of the tasks might have been planned too fast and she perceived them as impeded and consequently showed resistance.

The first two months of therapeutic sessions focused on playing different games with the girl, which did not involve verbal communication, such as Dobble, Uno, checkers. When the therapist noticed systematic anxiety diminution in contact with the girl, she decided to move on to another stage of the therapy connected with verbal contact. The patient's tasks consisted of loud speech (when the therapist had covered eyes) of one sound, later a word and finally a sentence. The same sequence of tasks took place during an eye contact with therapist. The next activity that took place in a therapeutic office, was listening together with a patient a book that was earlier read at home. After a few meetings in this shape, the patient started reading progressively louder selected parts of the magazines and short stories in the presence of the therapist. The final stage of communication as part of the therapy, was a spontaneous conversation initiated by the patient while watching of wedding photos where the girl assumed the role of a bridesmaid.

Due to the fact that the patient performed difficulties with communication in the school environment, teachers required detailed information and clues concerning the fact how to treat a child with selective mutism. After receiving the parents' consent, the psychotherapist decided to call the leading teacher and later, other teachers of the girl to give them strategic advice.

It seems to be important that strategies proposed by the psychotherapist were accepted by the headmaster and were systematically implemented. What is more, there was a designated coordinator – a Polish teacher, who was supposed to work with the girl at school.

After conversation with therapist, the girl decided that this teacher is a sympathetic person, and declared that she is going to cooperate with her.

Patient's parents were also involved in therapy. They were permanently in contact with educators. Every two weeks, there was a meeting with parents and the educator, during which various interventions in school environment were discussed and numerous suggestions concerning forthcoming stages of effects were given.

Before implementing next therapeutic steps in school environment, there was introduced a selective mutism psychoeducation for teachers who have contact with the patient, to define realistic aims concerning her active participation in classes and communication with the child. It was important that the girl was assessed for the second time by the psychologist conducting therapy and finally there was implemented the school demands adjustment to her abilities. It also considered her communication difficulties. After a few years at school, the girl was relieved when she could finally stop struggling with demands which were too high, overgrowing her possibilities. Working with the girl was focused mainly on building a strong bond between her and her Polish teacher by an intensive individual contact during corrective-compensation classes, almost every day at school. The teacher was informed about the need to stop any kind of pressure in order to force the child to start speaking. Initial meetings relied on communication via notes, drawings, watching photos, board games without speaking, listening to recordings made at home. Described activities were firstly introduced at the therapeutic office by the psychologist, later at school.

Later on, there was introduced the programme to get rid of the label of,, the girl of few words" at class. The girl started acting as a pupil on-duty, she used to give to other pupils notebooks during lessons and wipe the board. Every success was noted in a special activity notebook. After a few months, thanks to overcoming next steps, the girl was given rewards, such as a favorite phone game, going to the swimming pool or visiting a cousin who lives far away from her. Only after few months, the therapist decided to implement the system of positive reinforcements, because the patient needed more time to have a good relationship with other teachers. Unfortunately, it was also a consequence of teachers' lack of cooperation or availability. Despite giving guidelines on how to cooperate with their pupil, the therapist did not get the feedback from the teachers who agreed to help at the initial stage. The patient was perceived by them as a lazy and resisting girl. It had a decisive influence over the elongation of mutism treatment.

The next step, after having a positive bond between the girl and the teacher, was the activation of other pupils in classes. The therapist planned that during reading of girl's favorite book, she will be accompanied by her close friend. The patient was very eager to take part in these classes. There was a gradual growth in number of pupils engaged in listening texts that were chosen by the girl. The last stage of the school program

was reading one sentence, and finally a short text accompanied by all the classmates. The table below shows next cooperation steps and realized actions with the child at school (table 3).

Table 3. **School cooperation steps and realized actions**

School cooperation steps	Realized actions
1.	Phone conversation with form tutor and the Polish teacher (patient's coordinator)
2.	Meeting with the headmaster and acceptance the pupil's course of action at school
3.	Teachers' psychoeducation concerning selective mutism
4.	Intelligence test (conducted by the psychologist) and adjustment of school requirements to girl's cognitive abilities
5.	Next steps presentation for the form tutor and coordinator at school environment, education about positive reinforcements, conducting by teachers a special notebook with patient's behavior progress

Analyzing the girl's communication and her social development in other environments, there was observed a great progress. The patient, before starting the cognitive-behavioral therapy used to ask her sister to realize basic needs in order to avoid communication with strangers. During the meetings, the therapist introduced behavioral experiments such as visiting cafes and restaurants. The aim of the girl was to make an order via the contact with a waitress for herself and the psychologist, and paying the bill. Initially the waitress had to ask one more time for the order, because the girl was speaking too quietly, but next visits led to the growth of competence in this field. Every fulfilled therapeutic step was reinforced positively by the psychologist (a favorite game, oral praise, the place choice for the next visit). The aforementioned steps were practiced with parents (for example ordering ice creams by the girl, asking a strange person for a way to the restaurant during holidays). The table below presents next steps concerning out of school communication, with the psychologist or parents (table 4).

Table 4. **Steps of out of school communication and realized actions**

Steps of outside school communication	Realized actions
1.	Going to a restaurant with the psychologist – the place observation, planning the next action – ordering a dessert by the child
2.	Going to a restaurant with the psychologist and ordering a dessert by a girl
3.	Going to a bakery with the psychologist – the place observation
4.	Going to a bakery with the psychologist and buying breadstuff and a muffin by a girl

table continued on the next page

5.	Going to a shopping mall with parents and observation of buying ice creams by them
6.	Going to a shopping mall with parents and unassisted ice creams ordering

In conclusion, the therapeutic process was long-lasting, requiring the engagement of many people. The main aim of meetings, which was the girl's communication with persons other than family members, was achieved. The patient speaks to teachers, different strangers, does not express excessive anxiety in this type of situations. What is more, after coming back from school, she willingly speaks to parents about her emotions, difficulties that she experiences, which did not take place before.

Discussion

A very limited number of research concerning the selective mutism diagnosis and therapy among children and adolescents definitely impedes planning of therapy. SM is hardly understood by people who suffer from it, also by their families, other people and specialists who lack current knowledge and experience. The described patient's example confirms the newest research results concerning therapy, which emphasize the role of multidisciplinary interventions in order to reduce the level of anxiety felt by a patient. Most of therapeutic approaches underline also behavioral components in the cognitive-behavioral conceptualization, as mutism symptoms appear during childhood, and cognitive restructuring is difficult because of the child's age. The main elements of treatment are exposition gradation and positive reinforcements for building the connection. The essential factor in therapy is parents' and teachers' engagement, their psychoeducation and willingness to realize further steps of child's procedure. It is consistent with systemic approach, according to which a therapist should focus on rebuilding child's trust (by the parents) to beyond-parent environment. It must be underlined that the most important rule in mutism treatment is resignation of therapist and other people having contact with a patient, from an excessive emphasis towards child to start a conversation. By accepting other kinds of communication (such as gesture, facial expression, writing), the therapist shows respect for the child, and as a consequence encourages to establish positive relation, the development of oral statements, and as the matter of fact to psychosocial development.

References

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th ed. Wrocław: Edra Urban & Partner; 2018.
2. Cohan SL, Price JM, Stein MB. Suffering in silence: why a developmental psychopathology perspective on selective mutism is needed. J. Dev. Behav. Pediatr. 2006; 27(4): 341–355.
3. Krysanski VL. A brief review of selective mutism literature. J. Psychol. 2003; 137(1): 29–40.
4. The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Description and Diagnostic Guidelines. Kraków-Warszawa: University Medical Publishing House „Vesalius", the Institute of Psychiatry and Neurology; 2000.
5. World Health Organization. ICD-11 Reference Guide. https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/167946871
6. Hua A, Major N. Selective mutism. Curr. Opin. Pediatr. 2016; 28(1): 114–120.
7. Sharkey L, McNicholas F. More than 100 years of silence, elective mutism: a review of the literature. Eur. Child Adolesc. Psychiatry 2008; 17(5): 255–263.
8. Viana G, Beidel D, Rabian B. Selective mutism: a review and integration of the last 15 years. Clin. Psychol Rev. 2009; 29(1): 57–67.
9. Sharp W, Sherman C, Gross A. Selective mutism and anxiety: a review of the current conceptualization of the disorder. J. Anxiety Disord. 2007; 21(4): 568–579.
10. Muris P, Ollendick TH. Children who are anxious in silence: A review on selective mutism, the new anxiety disorder in DSM-5. Clin. Child Fam. Psychol. Rev. 2015; 18(2), 151–169. DOI: 10.1007/s10567-015-0181-y.
11. Steinhausen HC, Adamek R. The family history of children with elective mutism: a research report. Eur. Child Adolesc. Psychiatry 1997; 6(2): 107–111.
12. Kopp, S., & Gillberg, C. (1997). Selective mutism: A population-based study: A research note. Journal of Child Psychology and Psychiatry and Allied Disciplines, 38(2), 257-262.
13. Steinhausen HC, Juzi C. Elective mutism: An analysis of 100 cases. J. Am. Acad. Child Adolesc. Psychiatry 1996; 35(5), 606–614. DOI: 10.1097/00004583-199605000-00015.
14. Kristensen, H., Oerbeck, B., & Manassis, K. (2019). Selective Mutism. Pediatric Anxiety Disorders, 225–250. doi:10.1016/b978-0-12-813004-9.00011-6.
15. Gensthaler A, Maichrowitz V, Kaess M, Ligges M, Freitag CM, Schwenck C. Selective mutism: The fraternal twin of childhood social phobia. Psychopathology 2016; 49(2), 95–107. DOI: 10.1159/000444882.
16. Scott S, Beidel DC. Selective mutism: An update and suggestions for future research. Curr. Psychiatry Rep. 2011; 13(4): 251–257.
17. Edison SC, Evans MA, McHolm AE, Cunningham CE, Nowakowski ME, Boyle M, Schmidt LA. An investigation of control among parents of selectively mute, anxious, and non-anxious children. Child Psychiatry Hum. Dev. 2011; 42(3): 270–290.

18. Remschmidt H, Poller M, Herpertz-Dahlmann B, Hennighausen K, Gutenbrunner C. A follow-up study of 45 patients with elective mutism. Eur. Arch. Psychiatry Clin. Neurosci. 2001; 251(6): 284−296.

19. Kristensen H. Selective mutism and comorbidity with developmental disorder/delay, anxiety disorder and elimination disorder (2000). J. Am. Acad. Child Adolesc. Psychiatry, 39(2): 249–256.

20. Wong P. Selective mutism: A review of etiology, comorbidities, and treatment. Psychiatry 2010; 7(3): 23–31.

21. Viana AG, Beidel DC, Rabian B. Selective mutism: A review and integration of the last 15 years. Clin. Psychol. Rev. 2009; 29(1): 57–67.

22. Weisz JR, Kuppens S, Ng, MY, Eckshtain D, Ugueto AM, Vaughn-Coaxum R, Fordwood SR. What five decades of research tells us about the effects of youth psychological therapy: A multilevel meta-analysis and implications for science and practice. Am. Psychologist 2017; 72(2), 79–117. DOI: 10.1037/a0040360.

23. Zakszeski BN, DuPaul GJ. Reinforce, shape, expose, and fade: A review of treatments for selective mutism (2005–2015). School Mental Health 2017; 9: 1–15.

24. Holka-Pokorska J, Piróg-Balcerzak A, Jarema M. The controversy around the diagnosis of selective mutism – a critical analysis of three cases in the light of modern research and diagnostic criteria. Psychiatr. Pol. 2018; 52(2): 323–343.

25. Klein ER, Armstrong SL, Skira K, Gordon J. Social communication anxiety treatment (S-CAT) for children and families with selective mutism: A pilot study. Clin. Child Psychol. Psychiatry 2017; 22(1), 90–108. DOI:10.1177/1359104516633497.

26. Strawn JR, Welge, JA, Wehry AM, Keeshin B, Rynn MA. Efficacy and tolerability of antidepressants in pediatric anxiety disorders: A systematic review and meta-analysis. Depress. Anxiety 2015; 32(3), 149–157. DOI: 10.1002/da.22329.

27. Scharfstein LA, Beidel DC, Finnell LR, Distler A, Carter NT. Do pharmacological and behavioral interventions differentially affect treatment outcome for children with social phobia? Beh. Modification 2011; 35(5): 451–467. DOI: 10.1177/0145445511408590.

28. Anderson C, Thomsen P. Electively mute children: an analysis of 37 Danish cases. Nord. J. Psychiatry 1998; 52(3): 231–238.

29. Mulligan C, Shipon-Blum E. Selective mutism: identification of subtypes and implications for treatment. J. Education Hum. Development. 2015; 4(1), 79–96. DOI: 10.15640/jehd.v4n1a9.

e-mail: listwan.angelika@gmail.com