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Anxiety and oppositional behavior profiles among youth with selective mutism

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ABSTRACT

Selective mutism (SM) is a debilitating condition in which a child does not speak in social situations where speech is expected. The clinical conceptualization of SM has been debated historically, with evidence pointing partly to anxious and oppositional behavior profiles. Behavioral characteristics were examined in a clinical sample of 57 youth formally diagnosed with selective mutism. Parents rated children across internalizing and externalizing behaviors on the Child Behavior Checklist. Eighteen highly rated items were subjected to exploratory and then confirmatory factor analysis. Anxiety and oppositional behavior factors were derived. The anxious behavior profile was associated with social anxiety disorder symptoms, social problems, and aggressive behaviors but not oppositional defiant disorder symptoms. The oppositional behavior profile was associated with aggressive behaviors, oppositional defiant disorder symptoms, social problems, and inversely to social anxiety disorder symptoms. Results are consistent with emerging research regarding subgroups of children with SM. Behavior profiles are discussed as well with respect to assessment and treatment implications.

Learning outcomes: Readers will learn about the nature of children with selective mutism as well as behaviors that differentiate anxious and oppositional behavior profiles. Items that comprise anxious and oppositional behavior profiles are presented. These item profiles may have ramifications for assessment and treatment.

1. Introduction

Selective mutism (SM) is characterized by a consistent failure to speak in various social situations, most commonly school, despite speaking in other situations (American Psychiatric Association, 2013, p. 195). The duration of mutism must be for at least one month, and youth with little understanding of the dominant language or those with a communication disorder are usually excluded. Prevalence of SM is reportedly 1.0–2.0%, and the disorder is generally equivalent across gender with a typical age of onset of 2.7–6.0 years (Elizur & Perednik, 2003; Sharp, Sherman, & Gross, 2007).

Selective mutism is particularly relevant to those who work with children with speech, language, and communication difficulties. Indeed, language disorders and delays may be evident in as many as 20–68% of children with SM (Kristensen, 2001; Steinhausen & Juzi, 1996). In addition, speech and language pathologists are often the initial and sole professional

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contact for children with SM (Toppelberg et al., 2005). This is often the case because children with SM and speech and language delays may show a particularly prominent and debilitating clinical profile compared to children with SM only (Kristensen & Torgersen, 2002). Identifying the specific aspects of these clinical profiles may thus be helpful for speech and language pathologists and other professionals who commonly address this population.

Historical debate has surrounded the clinical conceptualization of SM. SM is listed as an anxiety disorder and a substantial literature base implicates general and social anxiety as key components of the problem (Schwartz & Shipon-Blum, 2005). Children with SM have been described in clinical settings as anxious, submissive, dependent, shy, timid, reticent, inhibited, fearful, withdrawn, and compulsive (Kristensen, 1997). Emotional inhibition may be a key aspect of many of these cases, in part due to the fear of negative consequences of speaking (Cohan, Price, & Stein, 2006; Popolo et al., 2014). Children with SM meet criteria for social anxiety disorder in very high percentages of cases (Vecchio & Kearney, 2005). Children with SM and children with social anxiety commonly share traits such as shyness and behavioral inhibition in addition to social skill deficits, separation anxiety, and socially reticent family members (Anstendig, 1999). Difficulties in theory of mind and thus impaired social judgments of others' thoughts and intentions may characterize some of these children as well (Facon, Sahiri, & Riviere, 2008).

Conversely, however, children with SM differ from children with anxiety disorders in key ways. The age of onset of SM is generally much younger than the age of onset of social anxiety disorder (Wong, 2010). In addition, levels of social anxiety have been found to be lower for youth with SM than youth with social phobia based on child self-report, and less than half of children with SM scored in the clinical range for social anxiety (Melfsen, Walitza, & Warnke, 2006). Youth with SM have also been found to be more socially and recreationally active than youth with general anxiety disorders and little different than controls (Cunningham, McHolm, & Boyle, 2006; Vecchio & Kearney, 2005). Children with SM often have active friendships even without a verbal component. Children with SM also tend to have more frequent expressive language impairments and developmental disorders than youth with social and other anxiety disorders (Manassis et al., 2003; McInnes, Fung, Manassis, Fiksenbaum, & Tannock, 2004).

Other researchers claim that oppositional behaviors also characterize some children with SM. Children with SM have been described in clinical settings as aggressive, stubborn, disobedient, controlling, negative, manipulative, suspicious, oppositional, and demanding (Andersson & Thomsen, 1998). Parents sometimes report strong-willed and oppositional behaviors in their children with SM, including stubbornness, irritability, argumentativeness, noncompliance, and tantrums (Ford, Sladeczek, Carlson, & Kratochwill, 1998). Others have found that as many as 29% of youth with SM have oppositional defiant disorder (Yeganeh, Beidel, & Turner, 2006). Problematic attachment and parent–child interaction patterns as well as emotional dysregulation have been implicated in some children with SM and may help explain oppositional behaviors (Ebner-Priemer et al., 2015; Egger & Angold, 2006; Nowakowski et al., 2011; Remschmidt, Poller, Herpertz-Dahlmann, Hennighausen, & Gutenbrunner, 2001). SM behaviors such as refusing to speak may be perceived by some as noncompliance or may be a reaction to an anxiety-provoking event (Keeton, 2013).

Children with SM may thus have various clinical profiles, a clearer identification of which may have important assessment and prescriptive treatment implications (DiStefano & Kamphaus, 2006). Cohan et al. (2008) proceeded in this direction by examining empirically derived clinical profiles in children with SM. Parents engaged in a screening for their child's symptoms of SM and provided ratings of anxiety and externalizing behavior problems. Latent profile analyses revealed three main groups: anxious, anxious-mildly oppositional, and anxious-communication delayed. Exclusively anxious children were the smallest subgroup, meaning that mixed clinical profiles with oppositionality and communication problems may be common in this population.

The present study was designed to extend this work by examining specific item profiles that may comprise clinical pictures of youth formally diagnosed with SM. The first hypothesis was that anxious and oppositional behavior item profiles could be derived statistically in a clinical sample of youth with SM. This hypothesis was based on the extensive literature linking SM to both anxiety and oppositional features (Viana, Beidel, & Rabian, 2009). The second hypothesis was that an anxious item profile would be associated with social anxiety disorder symptoms but not aggressive behaviors or oppositional defiant disorder symptoms. This hypothesis was based on previous evidence that many youth with SM have general anxiety symptoms without many oppositional symptoms (Vecchio & Kearney, 2005).

The third hypothesis was that an oppositional item profile would be associated with aggressive behaviors and oppositional defiant disorder symptoms but not social anxiety disorder symptoms. This hypothesis was based in part on recent evidence that SM can be associated with aggressive and delinquent behavior problems (Alyanak et al., 2013). The fourth hypothesis was that both anxious and oppositional item profiles would be associated with social problems, albeit possibly in different ways (e.g., social withdrawal versus socially aggressive behavior). This hypothesis was based in part on recent evidence that SM can be associated with substantial impairment in social behaviors compared to other diagnostic groups (Levin-Decanini, Connolly, Simpson, Suarez, & Jacob, 2013).

2. Material and methods

2.1. Participants

Participants were 57 youth (M_{age} = 6.74 years, SD = 1.92) receiving treatment for SM at a specialized university-based clinic for youth with anxiety disorders. Participants (59.6% female) were European American (45.6%), Hispanic (21.1%),