Battling Anxiety with Selective Mutism

An investigative study aimed to measure the level of awareness and attitude of teachers and students towards a Selectively Mute child, as well as discovering the conditions impact on the child's academic development in Private Primary Schools in Dubai.

محاربة القلق الاجتماعي بالصمت الاختياري

دراسة استكشافية تهدف إلى قياس مستوى الوعي وموقف المعلمين والطلاب تجاه الطفل الذي لديه حالات الصمت الاختياري، بالإضافة إلى اكتشاف مدى تأثير الحالة على التنمية الأكاديمية للطفل في المدارس الابتدائية الخاصة في دبي.

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Dissertation submitted in partial fulfillment of the requirements for the degree of Masters of Education in Special and Inclusive Education.

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March 2016

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ABSTRACT

Selective Mutism, compared to other disorders, has received minimal attention due to its rarity that consequently makes it understudied and under researched. Therefore, children with SM have been constantly dismissed as shy or having personality insecurities, or other social disorders, inadvertently diminishing the seriousness of their social anxiety. Lack of awareness and positive attitude are the primary factors in allowing the condition to persist and worsen, as the children grow older making it more difficult to overcome. Thereby, it is paramount for an SM child's successful treatment to have access to early intervention, including the support, acceptance and understanding of those surrounding him, that is achieved through sufficient knowledge of the condition and appropriate intervention plans. This research measured the level of awareness and attitude of both teachers and students who are in daily contact with the SM child at school. The following was uncovered through the usage of surveys, by questioning teachers and students about their knowledge and experience of having an SM child in the classroom. Much of which proved the existence of a high level of lack of awareness among the 200 surveyed individuals of both teachers and students. On the other hand, there seemed to be a generally positive attitude and a strong willingness to help the SM child overcome their anxiety that was reflected by both categories.

Besides measuring awareness and attitude of others, it is equally important to assess whether the condition affects a child's academic development, however results proved no relation between SM and a child's academic development. In conclusion, the research primarily aimed to clarify doubts, myths or misconceptions commonly held by the two participating categories with regards to SM.

ملخص

يتلقى الخرس الانتقائي مقارنة بباقي الاضطرابات الحد الأدنى من الاهتمام نظراً لندرته وقلة الدراسات حوله. ولذلك غالباً ما يتم صرف النظر عن الأطفال ذوي الخرس الانتقائي من خلال ربط حالتهم بالخجل أو اضطرابات شخصية أو اجتماعية أخرى مما يؤدي إلى التقليل من أهمية هذا الاضطراب الاجتماعي دون قصد. كما يعتبر قلة الوعي وانعدام الموقف الإيجابي من العوامل الأساسية التي تسمح للحالة بالاستمرار والتفاقم مع نمو الأطفال، مما يجعل ذلك أكثر صعوبة في التغلب عليها. ولعلاج طفل ذو خرس انتقائي بشكل ناجح فإنه من الضروري التدخل المبكر من خلال الدعم والقبول والتفاهم مع المحيطين به. وهذا يتحقق بالمعرفة الكافية للحالة وخطط التدخل المناسبة.

يقيس هذا البحث مستوى الوعي وموقف كلاً من المعلمين والطلاب الذين يحتكون بطفل ذو خرس انتقائي في المدرسة يومياً من خلال استخدام الاستبانات وسؤالهم عن معرفتهم وخبرتهم تجاه وجود طفل ذو خرس انتقائي في الفصل الدراسي. وأثبتت النتائج عن عدم وجود وعي بشكل كبير بين المئتين شخص الذي شملهم الاستطلاع. كما أثبتت النتائج أيضاً وجود موقف إيجابي عموماً ورغبة قوية لمساعدة طفل ذو خرس انتقائي للتغلب على قلقه.

بالإضافة إلى قياس مستوى الوعي وموقف الآخرين، فمن المهم أيضاً تقييم إذا ما كانت هذه الحالة تؤثر على التقدم الأكاديمي للطفل. إلا أن النتائج لم تثبت وجود أي علاقة بين الخرس الانتقائي للطفل وتقدمه الأكاديمي. وفي الختام، فقد هدف هذا البحث في المقام الأول إلى توضيح الشكوك أو الخرافات أو المفاهيم الخاطئة الشائعة بين الفئتين المشاركتين من المعلمين والطلاب فيما يتعلق بالخرس الانتقائي.

ACKNOWLEDGEMENT

I would like to take this opportunity to firstly thank God the Almighty for giving me the strength and resilience to continue this journey and for blessing me with the patience and support of those surrounding me in helping me morally and emotionally to finish this research. I would also like to immensely thank my family, mostly my mother and father, and friends, especially Alia Ibrahim, who has shown unlimited support and generosity in their tolerance of my temperaments and showering me with infinite words of encouragement. Not to forget the exceptional efforts and ceaseless assistance of my esteemed professor Dr. Eman Gaad, who has unfailingly answered each and every of my inquiries along the way and has welcomed me with open arms to her office. I could not have done it without the amazing people in my life. Last but not least, I extend a special thanks to my dearest husband Khalifa Al Habtoor for being there for me every step of the way and motivating me through tough times. I appreciate each and everyone of you. Thank you to one and all.

شكر وعرفان

أود أن اغتنم هذه الفرصة أولاً لأشكر الله سبحانه وتعالى الذي منحني القوة والقدرة على مواصلة هذه المسيرة وأنعم علي صبر ومساعدة المحيطين بي لإنهاء هذا البحث. وأود أيضاً شكر عائلتي كثيراً وخاصة أمي وأبي. كما أن أريد أن أشكر أصدقائي وبالأخص علياء إبراهيم التي أظهرت دعماً غير محدود وسخاء في مدى تحملها وتشجعيها المستمر لي. ولن أنسى الجهود الاستثنائية والمساعدة المتواصة من أستاذتي المحترمة د. إيمان جاد التي كانت ترحب بي وتجيب على جميع تساؤلاتي طوال هذه الفترة. وأتقدم بالشكر و التقدير لزوجي العزيز خليفة الحبتور لوقوفه بجانبي خطوة بخطوة و دعمه اللامحدود في أصعب الأوقات. أنا لم أتمكن بالقيام بهذا العمل من دون وجود أناس مذهلين في حياتي. فأنا أقدر كل شخص منكم. فشكراً لكم جميعاً.

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ABBREVIATIONS

SM	Selective Mutism
DSM	Diagnostic Statistical Manual
UAE	United Arab Emirates
MOE	Ministry of Education
UNICEF	United Nations International Children's Emergency Fund
UNESCO	The United Nations Educational, Scientific and Cultural Organization

CHAPTER ONE

Introduction

Rewind back your memory to a time when you had to present an important presentation in front of a large audience, a speech or even pitch an idea. You feel butterflies in your stomach as the curtains open and all of a sudden you are the center of attention. This feeling of nervousness and anxiousness is called stage fright (Wettston, n.d.). This can be somewhat similar to how a selectively mute child feels about speaking.

Selective Mutism is a rare condition where a person usually capable of speaking constantly fails to talk in specific places such as at school, and to specific people such as the teacher or peers in the classroom (Shipon-Blum et al., n.d.). Therefore, it is the responsibility of educational researchers and experts in the field to provide appropriate and applicable interventions, in order to correctly deal with SM individuals at an early stage to prevent its persistence.

1.1 Background and Purpose of Study

Not only is it important to provide solutions and intervention plans, it is equally important to highlight the level of awareness and attitude of the people who are in daily contact with the SM child, as they are the deciding factor whether the intervention plan will be a success or a failure. In order to measure the levels of awareness and attitude, teachers and students will be the focus of the research, in addition to assessing the impact of SM on a child's academic development. The objective being to clear any doubts, myths or misconceptions attached to the condition and enabling both teachers and students to appropriately attend to an SM child's social needs.

Black and Uhde (1992), stated that selective Mutism normally becomes visible when children are between the ages of 2-5 years old. Though diagnosis is not made until the child is between the ages of 6-8, because it is hard for parents to differentiate selective Mutism from shyness. They consider their child's unwillingness to speak in specific settings or with people as simply a period that they will eventually outgrow. But it is

only later that it becomes more obvious when the child first enters school, got the chance and appropriate amount of time to attune to the new transition and warms up to the new school setting, that selective Mutism is clearly diagnosed due to the fact that the condition persisted for a long period of time (McHolm et al., 2005).

A research conducted in elementary schools stated that even though selective Mutism was initially considered rare, this study proved that the condition is present in 2% of children, in addition to appearing twice as more common in girls than boys (Krysanski, 2003).

The Diagnostic Statistical Manual (DSM) serves clinicians and mental health professionals with descriptive diagnostic categories to help them in diagnosing mental health disorders. In relation to Selective Mutism, DSM 1 (1952) and DSM 2 (1968) did not include Selective Mutism. It was not until DSM 3 was published in 1980, that it included Selective Mutism, formerly named Elective Mutism (Newman, 2004).

Due to the fact that it was considered a rare and low public interest disorder, it was ignored and there were only a few studies and single case studies based upon theories. Therefore, there were conflicting theories where the majority considered it as refusal to speak, in other words a choice. Along with characteristics varying from being shy, willful, controlling, manipulative behavior and outright defiance (Newman, 2004).

This was massively overwhelming for parents that were looking for help to treat their selectively mute child. Based on these reasons of the DSM misconceptions, parents were held responsible for their child's silence, stating that it was due to abuse, too many children, not enough children, working full time, not enough bonding, neglecting to breastfeed during infancy, keeping family secrets of dysfunction, spoiled, angry, seeking attention or stubborn. As a result, unfit classifications took place as selectively mute children were referred to speech and language therapy, isolated programs for the emotionally disturbed, specific learning disability classes, occupational therapy, physical therapy, denied extracurricular activity or simply ignored as they are seen as undisruptive in the classroom (Newman, 2004).

Fortunately, with the initiation of the Selective Mutism Foundation's powerful impact over Selective Mutism (SM) on the DSM of Mental Health Disorders in 1991, it was the main resource reducing conflicting theories and substituting them with accurate facts.

There were definitely important alterations created by the SM Foundation between DSM 3 (1980), it was called Elective Mutism and the diagnostic feature was "Continuous refusal to speak in almost all social situations. Some have delayed language development and articulation abnormalities" with associated features of "shyness, school refusal, encapresis, enuresis" compared to an update in DSM-4-TR (2000), with diagnostic features being: "Failure to speak in specific social situations, Selective Mutism should not be diagnosed if solely due to lack of knowledge of required spoken language. Selective Mutism should not be diagnosed if related to embarrassment of communication disorder" and associated features being "Shyness, fear of social embarrassment. Generally normal language skills, occasional associated Communication disorders. Clinicians almost always give additional diagnosis of Anxiety disorders, especially Social Phobia." However, in comparing DSM-4-TR to DSM 5 (2015), selective Mutism was removed from being classified in the section of "Disorders usually first diagnosed in infancy, childhood, or adolescence" to being classified under "Social Anxiety" (Newman, 2004).

Even though studies show that it is a rare condition, people are not aware of its seriousness and increase of occurrence among children. In most cases it has been seen that the child is just being shy and that the child will eventually outgrow this behavior (McHolm et al., 2005). Despite this not being an unreasonable assumption, it has been stated in the UNESCO Salamanca statement (1994) that it is the right of every child to have access to education, taking into consideration the wild diversity of learners having different characteristics, interests, abilities and individualized learning needs to achieve appropriate standards of learning (The UNESCO Salamanca Statement, 2016).

Relating the statement to selective Mutism, it is the child's right for their parents or professionals in school to help the child overcome this condition because there are cases where selectively mute children not only struggled socially but academically

because the condition persisted through primary, middle and high school making it harder for the child to get over their fear and anxiety of speaking (McHolm et al., 2005).

Therefore, the purpose of my research study is to spread awareness about selective mutism to help teachers, parents and professionals who are in direct contact with the child to learn about selective mutism and clear any doubts, myths or misconceptions. Allowing them to find different successful individualized intervention plans for the SM child, because despite having similar characteristics, it affects each child differently. As well as informing typically developed children about SM to enable them to become creative in finding ways to make the classroom the least restrictive learning environment, therefore helping the child feel more comfortable in turn reducing their anxiety level.

With an increased level of awareness, combined with a positive attitude towards selective mutism, parents, teachers and professionals will be more knowledgeable and attentive towards signs or characteristics of SM. As not having effective intervention plans the child will develop a habit of not speaking by using behavioral inhabitation or avoidance behavior as a technique to deal with their anxiety. It is a behavior where the child shows minimal behavioral or verbal activity by a freeze response (Burgess et al., 2001). Thus, early intervention will help the child work through their SM instead of finding coping mechanisms. It will also prevent the child from having a non-speaking identity and considered a non-speaker by their peers and teachers, learning difficulties and long lasting socialization problems (McHolm et al., 2005).

In regards to socialization, there are 4 significant features of child development that have an influence on social development such as: social cognition, verbal and non-verbal pragmatics, receptive and expressive language processing and lastly social interactions (Adams, 2005). Therefore, it is evident that children suffering from SM are not developing as expected in that area, due to the fact that they have limited or no social interactions which prevents them from acquiring social skills that will allow them to adapt to the requirements of a social life (Smith and Sluckin, n.d.).

As mentioned in UNICEF (Early Childhood Development: The key to a full and productive life, 2001), early childhood is a seriously significant stage of development that creates the basis for future child learning and well being. Nevertheless, early intervention can have permanent influence on intellectual capacity, personality and social behaviors. But failure in providing early intervention will result in the child having developmental delay, disabilities or hinder the ideal growth and function (Odom, 2003).

1.2 The Research Questions

This investigative research is a case study of primary private schools in Dubai, aiming to measure the level of awareness and attitude of teachers and students towards selectively mute children. In addition to exploring whether SM can affect a child's academic development.

Therefore, the research question will be divided into three focus areas:

- To what extent are teachers and students aware of SM?
- What is the attitude of teachers and students towards a selectively mute child?
- Does SM have an impact on the child's academic development?
- To what extent were the teachers and student recommendations in dealing with an SM child useful?

1.3 Organization of Chapters

There are a total of 5 chapters in this research study. Chapter 1 starts with a brief introduction about the background of SM. It then states the purpose and significance of this study, along with the research question to allow readers to have a clear knowledge of what this thesis is about.

Chapter 2 will be the review of related literature studies. The first part of the chapter will define SM as well as the history of terminology shift of this condition throughout the years, which will show us a development of a better understanding of the condition. The second part of the chapter describes the characteristics, causes and

development of SM. Finally, the chapter concludes by mentioning current schooling systems in Dubai and the inclusion of SM in primary private schools in Dubai.

Chapter 3 is the methodology of the study. The research design will be clearly described such as who are the population of the study, when, where and how will it take place. The chapter will focus on the research strategy stages, data storage, data analysis, limitation and challenges of the study.

Chapter 4 will cover the results and discussions of the research and data analysis.

Chapter 5 will include the conclusion, summarizing the key findings of the research.

CHAPTER TWO

Literature Review

2.1 Definition of SM

The way scientists, clinicians or researchers tend to name a condition is influenced by what they think it is or what they believe causes it. Regardless of the fact that the term 'SM' has only fairly recently been used in literature, the condition associated with children not speaking at specific times was known for well over a century. However, there were terminology shifts throughout the century influenced by recent updates discovered about the condition. To begin with, in 1877, Adolph Kusmall, a German Physician, used to describe the condition as *Aphasia Voluntaria*. He believed that even though the child was able to speak, it was a voluntary behavior to not speak in specific places or to certain people (Cline and Baldwin, 2004).

Later in 1934, Motiz Tramer, a Swiss Child Psychiatrist, used to describe the condition as *Elective Mutism* believing that it is a principle of choice in electing who they would and would not speak to (Halpern et al., 1971). There were many changes in perspective, for instance in early 1971 a multi-disciplinary team in Rochester, New York, believed the condition was a social phobia while Heidi Omdal of Stavanger in Norway argued that it is a "specific phobia of expressive speech." While in 1992, Black and Uhde who were the first to adopt a large-scale study of SM, found the majority of the sample suffering from high level of social anxiety (Omdal and Galloway, 2008).

For the purpose of our understanding of this research, the condition or term: SM, will be defined according to the DSM-5 stating that it is: "*a consistent failure to speak in specific social situations in which there is an expectation for speaking, despite speaking in other in other situations"* (Newman, 2004).

2.2 Diagnostic criteria

SM is referred to in the 2014 DSM-5 as a condition with the following features:

1- Regardless of possessing the ability to speak fluently, there is a continuous incapability of speaking in particular circumstances where speech is required, despite speaking at various other instances.

2- Educational, occupational and social communication attainment become restricted and hindered.

3- The period of disturbance is no less than one month, without the consideration of the first month of school.

4- The regular inability to speak is not caused by lack of knowledge or confidence with the spoken language expected in the social circumstance.

5- The condition is not always present with autism spectrum disorder, schizophrenia, or another psychiatric disorder, nor is it better clarified by a communication disorder.

(Newman, 2004)

2.3 Characteristics of SM

Individuals with SM will reflect some but not all of the characteristics described below:

- Selectively speaks at some social circumstances or places, while not speaking at others.
- Dependent on using non-verbal communications such as gestures, pointing or nodding as an alternative to verbally speaking.
- Can reveal physical symptoms of clear anxiety such as being physically frozen at times.
- Avoidance of eye contact, lack of smiling, regular tantrums and fidgeting in the classroom.
- Displays shyness, sadness or socially withdrawn mannerisms.
- Reflects signs of other anxiety related disorders, such as social phobia, separation anxiety, and perfectionistic or obsessive tendencies.
- Practices defiant, stubborn, oppositional, contrary, manipulative or willful behavior.

- Manages to effectively create an environment where other typically developed individuals accept and compensate for the child's silence.

(Black and Uhde, 1995)

2.4 Factors that may contribute to SM

According to research SM is associated with anxiety. However, there is inadequate research to sufficiently reason other factors that play a role in triggering the presence of SM. In spite of this, at this point we relay on research and clinical observations that state some aspects that seem to influence or occur with SM. Below are some of these factors:

- A shy or anxious temperament

Scientists question the concept of considering SM as a separate disorder from social anxiety. They supposed that SM might be a symptom of social phobia, by arguing that the child's social anxiety falls on a spectrum, with SM being the uttermost intense type (Dummit et al., 1997).

Nevertheless, children who are considered to be shy or have an anxious temperament tend to be slow to adjust and settle in unfamiliar settings or situations. They are also commonly referred to as being sensitive, hesitant, timid and occasionally frightened. Therefore, when they are frightened or are panicking due to an anxiety-provoking situation such as asking them to speak in school, they become silent by restricting their behavioral and verbal activities to feel better (McHolm et al., 2005).

There are parents that report having a family history of shyness and anxiety. It may be present in one or both parents, sibling, uncle or any member of the family previously or currently reflecting symptoms of the condition. Thus, with family history taken into account, along with the child's habitual disposition towards shyness means that there are scarcely any role models in the child's life that represent confidently assertive or sociable way, of behaving. This unfortunately results in leaving the child to imitate shyness and anxious behaviors that will eventually be profoundly implanted in the child until it becomes a personality trait (McHolm et al., 2005).

- A family history of shyness or anxiety

It is not yet known whether anxious tendencies are due to genetic or situational factors. Though scientists are uncertain if anxiety disorder runs in the family, there are parents that stated having comparable characteristics as their child (Kristensen and Torgersen, 2001).

But what scientists are certain about due to research conducted in this aspect, is the fact that there are no specific parenting styles that trigger the appearance of SM. Because when analyzing the results of the research there was no difference when comparing parents of children with SM to parents of typically developed children (Cunningham et al., 2004).

- Speech or language difficulties

Even though children with SM may also suffer from speech and language difficulties or have a history of delayed speech development, it is an indefinite factor to state that children with SM are more likely to have speech and language difficulties compared with other children. In spite of this, those with speech and language difficulties may be cautious towards talking and therefore stay silent as a way to avoid allowing others to listen to their imperfectly inadequate speech, while also decreasing the chances of being mocked and teased for the way they speak (Cleator and Hand, 2001).

- Adjustment to a new culture

Moving from one country to another means you will be introduced to new cultures that may speak a different language and practice different customs and traditions. Therefore, immigrant children reflect having a higher dominance of encountering the condition (Elizur and Perednik, 2003).

Going to a new school is without a doubt an extremely intense and stressful experience for the child due to the fact that they will meet new people such as teachers and peers and will be expected to learn to speak a language different from their native language used at home, in addition to accepting and practicing new customs and traditions. Thus, becoming a contributing factor to the emergence of SM (McHolm et al., 2005).

- Limited socializing with school peers away from school

Sociologists found a link between having healthy social relationships to having a positive outcome on a person's health and wellbeing. Therefore, having a weak connection between home and school peer networks due to the family being socially isolated, as they would prefer to spend time solitarily and enjoy family oriented activities rather than with strangers or friends, as well as, not putting an effort on planning play dates for their child and not knowing the members of their neighborhood, increases the risk of developing SM. Another case may be the child lives geographically distant from the school, thus does not have enough or any connection with peers from his/her classroom or school (McHolm et al., 2005).

- Early trauma

Professionals in this specialty dismiss early trauma as being the original key component in the appearance of SM due to lack of high quality research on this aspect (Dummit et al., 1997). However, there is a small scale of individual cases that disabled the child to speak straightaway after a traumatic or highly stressful event which may include early hospitalization, death of a loved one, divorce or frequent family moves. But this is not to generalize nor elucidate its motive behind the occurrence of SM (Steinhausen and Juzi, 1996).

- Family problems

As claimed by primitive theory, youngsters who are afflicted with SM are conveying traits of dysfunctional family relations. This literature states that the mother-child relationship is unfit and dependent on each other due to the fact that the mother is more dominant and preservative while the father is obstinate and faraway. Thus, it proposes that the child learns to be suspicious and distrustful towards individuals that are not members of the immediate family, which results in the individual being silent which can be interpreted as a way to harbor family secrets (Hayden, 1980). Family dysfunctions may be one of the causes on the development of SM, although these researchers are theorizing without having reliable verification to support their point of view due to lack of sufficient research studies (Kristensen, 2000).

Even though SM can be diagnosed at an early age of 3 years, when they first enter preschool or daycare, some go unnoticed at this age. This being due to lack of awareness of the condition implying that they are simply shy children or have an introvert personality that may require more time to warm up and adjust to the change of meeting new people and spending time in a new unfamiliar setting. In other words, stalling and practicing the 'wait and see' approach, believing that the child will eventually grow out of it (Smith and Sluckin, n.d.).

There are some maintaining factors that hinder the child's process of finding treatment. These factors include misdiagnosis, lack of early and appropriate interventions due to lack of understanding by family, teachers, doctors or any individual that is in direct contact with the child and is responsible for their wellbeing. Also, even though parents play a big role in helping their child overcome the condition by trying to create a comfortable environment that may promote them to speak, they instead use negative reinforcement by speaking for the child instead of encouraging them to participate socially. In contrast to other negative maintaining factors that include applying pressure for verbal communication over the child, which only increases the child's anxiety levels (Smith and Sluckin, n.d.).

These maintaining factors will make it harder to treat the child with SM especially when they enter elementary school, which is considered a more rigid school environment compared to preschool or daycare. This is because mutism is ingrained and the child may have already created coping mechanisms to reduce their anxiety, via behavioral inhabitation and avoidance behavior. Also, the child would have already set rules for whom, when and where to speak (Smith and Sluckin, n.d.).

2.5 Difficulties associated with SM

According to literature on SM, there are numerous emotional and behavioral difficulties that are reported as occasionally co-existing with the condition. Therefore, in this section the most frequently invoked issues will be described based on scientific confirmation (Dummit et al., 1997).

1. Other Anxiety-Related issues

Studies stated evidence that children with SM tend to be more anxious when compared to other children of the same age, not solely in circumstances where talking is expected, but also in other situations as well. Thus, in most cases the child with SM is more likely to be diagnosed with at least one other anxiety related problem (Dummit et al., 1997).

2. Social phobia

The link between SM and social phobia is the fact that among the possible appearing psychological problems with SM, social phobia is considered one of them. However, other researches argue that the relation between the two conditions is still vague and unclear, due to the fact that there are some differences between them such as symptoms of children with SM appear between the ages of 2-4, while social phobia appears between the ages of 10-11 (Beidel et al., 1999).

Not only that, but also children with SM can communicate confidently using non-verbal communication, in contrast to a child with social phobia who avoids any social engagements to prevent the risk of being embarrassed in public or being negatively judged by others. Therefore, it is an essential parental role to observe their child while interacting with other children to be able to identify if the child is also encountering anxiety when socially engaging with others (McHolm et al., 2005).

3. Separation Anxiety

It is typical for most children at a young age to feel anxious and sometimes fearful when being separated from a parent in order to attend school. It is considered as a normal stage of development. However, if the anxiety escalates and continues for a long period of time it will without a doubt hamper the child from participating in activities which will disrupt his school performance. In this case, the child is diagnosed with separation anxiety. Research states that between 20-30 percent of children with separation anxiety are also declared as having SM (Kristensen, 2000).

4. Perfectionistic of Obsessive Tendencies

Obsessions can be defined as a continuous tenacious assumption or visualizations, that can be equated with anxiety or distress, influencing an individual to be convinced by the fact that their surrounding environment requires to be a specific way, or lead

them to be excessively cautious about making errors. Regarding this issue, more parents with selectively mute children set forth the fact that they observe indicators of perfectionistic and obsessive tendencies in their child compared to parents of typically developed children (McHolm et al., 2005).

5. Fear of using Public Toilets

The reason behind an SM child's fear of using public toilets, such as in school is still indefinite. It is still indefinite for the reason behind the child with SM to fear using public toilets in the community, such as school. There are several cases of the child experiencing wetting accidents as parents and teachers provide a justification for the incident by stating that the child does not use the bathroom all throughout the school day because they are insecure and timid towards this anxiety provoking situation. The situation would include having to ask for permission from the teacher, which would mean the child will have to raise his or her hand, followed by issuing the request, all the while drawing attention to him or herself during the process, thus causing them anxiety (McHolm et al., 2005).

6. Oppositional Behavior

Some studies stated a common occurrence of oppositional behavior among children with SM (Kristensen and Torgersen, 2001), some parents have described their selectively mute child as being stubborn, defiant, manipulative and demanding (Dummit et al., 1997). None of the characteristics or disturbances that the child's teacher faces in school, because the child is unable to speak at school (Cunningham et al., 2004).

However, in cases where the teacher experiences silent indication of resistance the child is described as being determined, obstinate and dismisses to abide by classroom orders. The described behavior is a reflection of the child's strategy of evading apprehensive conditions, as this behavior is anxiety based rather than deliberate failure to act appropriately or as expected. It is considered a typical behavior of some selectively mute children (Dummit et al., 1997).

2.6 Treatment approaches

This section will be discussing the available treatment approaches commonly used to deal with SM.

1. Psychodynamic Approach

For the duration of this approach, the main objective of the counselor is to avoid immediate confirmation of the mutism yet, instead comprehend and unravel the causal source (Cohan et al., 2006). The steps to achieving this are as follows:

- Explore early psychosexual stages of development.
- Analyze the mother-child relationship.
- Then eventually confront the fears directly with the child (Cline and Baldwin, 2004).

Features of this condition are embedded in anxiety. That being the case, insistence to verbalize thoughts and emotions is a drawback in this approach because it can be extremely devastating for the child. Moreover, even though verbalization can be achieved thorough non-verbal communication, the child might still feel stress and experience a sense of discomfort simply by being seated in the counselors office, knowing what is expected from him or her (Camposano, 2011).

However, when all strains and tension for speaking is detached along with prominence focused on assisting the child to feel relaxed and loosen up, only then will the therapeutic approach be successful (Shipon-Blum, 2007).

Psychodynamic projective involvement is related to the unconscious transfer of ones desires or emotions to another person through several ways such as:

- Play Therapy

The essence of play is a beneficial and useful strategy to reduce anxiety due to the fact that it generates a harmless atmosphere that encourages the creation of a healthy counselor-child connection unaccompanied by the emphasis on expecting the child to speak (Hultquist, 1995).

- Music Therapy

Supports the child to convey both thoughts and feelings by non-verbal methods. Therefore, emphasizing the feeling of safety will allow the child to reflect their feelings and emotions. Thus, giving the qualified music therapist access to explore the child's inner world (Amir, 2005).

- Art Therapy

Regarded as a springboard for verbal communication. It gives the child the chance to nonverbally express feelings and fears. Hence, improving the child's self-esteem and gives the counselor the ability to slowly construct a bond with the child in a less threatening and much welcoming environment (Cline and Baldwin, 2004).

2. Behavioral Approach

In this approach, SM is viewed as a learned behavior to assist the child in managing their anxiety. Thus, the treatments intention is to reduce anxiety to promote the child to speak in specific settings (Cohan et al., 2006), such as school through various techniques that include:

- Shaping

Encourages mouth movements and sounds that correspond to speech. This is achieved by following a step-by-step method of dividing goals of verbal communication into smaller steps (mouthing words, making sounds, whispering, repeating words, and after a period of time higher volume speech) that meets the child's needs, as this will help in lowering their anxiety (Camposano, 2011).

- Self-modeling

The child speaks and answers questions using an audio or videotape, in the least restricted environment. Following that, the tape content is edited to show the child speaking in a school setting. After the repetitive listening of the tape the child adapts to hearing him/herself speaking in school (Blum et al., 1998).

Another method of this technique is the participation of family members as they recorded questions that the child could be asking in school (Cline and Baldwin, 2004).

Next, the child is required to rehearse by repeating answers verbally. Even though research indicated successful outcomes by the use of this technique, it is not appropriate for all selectively mute children as this may instead intensify their anxiety level (Blum et al., 1998).

- Contingency management

Integrates positive reinforcement to motivate the selectively mute child to repeated exercises in performing the use of verbal communication to acquire proficiency in it.

The American behaviorist B.F Skinner, states that certain wanted behavior would be repeated if positive reinforcement took place immediately after the behavior was practiced (Skinner, 1953).

In the case of this technique, contingency management is applied in cooperation with systematic desensitization where the goals of verbalization are ranked in hierarchy starting from the least difficult i.e. least anxiety provoking, to the more anxiety provoking. But taking into account the locations, activities and people that have an impact towards the child's level of comfort. Therefore, after the successful completion of each hierarchy level the child is rewarded (McHolm et al., 2005).

Comparable to systematic desensitization, stimulus fading is often used, where the child would be gradually and moderately exposed to an anxiety provoking situation (after being taught relaxation skills due to the likelihood of anxiety elevation) such as increasing the number of students entering the classroom while the child participates in verbalization, which is then followed by positive reinforcement (Camposano, 2011).

3. Cognitive-Behavioral Approach

The objective of this treatment program is to assist selectively mute children to alter their behavior by teaching them using various strategies to redirect their anxiety stress, concerns or fears in a beneficial manner.

This is accomplished by integrating behavioral methods such as systematic desensitization and stimulus fading, but adding to it the importance of the teaching

and understanding of anxiety management education to both parents and child (Chansky, 2004). Also, ensures that the child learns particular skills to be able to target thoughts, physiological responses and behaviors that are related to anxiety and redirecting them in a healthy manner (Shipon-Blum, 2007).

A significant feature of this treatment program is regular assessments during meetings to explore the elements that play a part in triggering the child's anxiety. This will help in creating and choosing the most suitable treatment plan that will sufficiently meet the child's needs (Chansky, 2004).

Therefore, there are numerous case studies supporting the success of this approach. Yet, the downside is the fact that it requires commitment due to the fact that it is time consuming and demands patience (Camposano, 2011).

4. Pharmacological Approach

When the child suffers from severe or weakening symptoms of SM, to the extent that the anxiety comes in the way of their academic development in school, and the engagement in counseling treatment becomes strenuously problematic the client is prescribed with medication to get control of their anxiety associated with SM. Hence, increasing the chances of the child in using verbal communication (Camposano, 2011).

Since anxiety problems are known to be caused by an imbalance in the neurotransmitters or the chemical messengers in the brain, medication could at times assist in lowering their symptoms. Authorized medication can include Selective Serotonin Reuptake Inhibitors (SSRIs), Monoamine Oxidase Inhibitors (MAOIs), or other supplements depending on the severity of the case (Kearney and Vecchio, 2007).

According to research, this approach provides promising results to overcome SM. However, not enough information on the effect of long-term treatment using medication is yet conducted (Kearney and Vecchio, 2007).

5. Family Therapy

An essential element for successful therapeutic intentions is the involvement of family members during the course of treatment (Anstendig, 1998). Family engaging in counseling has revealed several cases of disruption within the families such as marital conflicts, divorce and other family related issues (Viana et al., 2009).

The key objective of this treatment plan is to recognize defective family connections and suggest guidelines that could possibly reduce the development of the child's anxiety (Cohan et al., 2006).

During this treatment plan the family are taught:

- Acknowledgment and acceptance of the disorder is significant.
- Avoid parental insistence on the absence of verbal communication.
- Child's efforts and attainment must be celebrated.
- Adjustments to parenting styles may be required.
- Generate beneficial management mechanisms for the child to cope with stress and fear associated with the anxiety.
- Give moral support and acceptance of the child's struggle and exasperation.
- Prepare and qualify parents to model appropriate and healthy coping abilities for their children.
- Avoid focus on the child's lack of verbalization while keeping track of how much the child uses non-verbal communication.
- The significance of family members in acknowledging the importance of not answering or speaking on behalf of the child during social engagements.
- Stressing the significance of rewarding the child through positive reinforcement.

(Sharkey and McNicholas, 2008)

Even though there is not enough research conducted on this aspect, there are highly positive effects on recovery outcomes (Camposano, 2011).

6. Multifaceted Approach

Due to the complexity of SM, there has been powerful emphasis on the use of multifaceted approaches as a course of treatment. It targets anxiety at different settings along with the involvement of the child's teachers, peers, parents and other family members. Therefore, a wide-ranging approach combining psychodynamic, behavioral, cognitive behavioral, pharmacological and family intervention approaches is essential. Thus, it has been rated 'successful' among researchers in the field in their published case studies (Camposano, 2011).

2.7 Schooling System in the UAE

In this section the UAE will be brought into focus with a look into its schooling system and their inclusion of children with special needs in mainstream schools and the law concerning individuals with special needs.

- UAE Background

The fundamental impelling force responsible for the initiation and creation of the relatively new confederation of the United Arab Emirates was the late His Highness Sheikh Zayed Bin Sultan Al Nahyan. He successfully unified the six trucial states on the 2nd of December 1971 which included Abu Dhabi, Dubai, Sharjah, Fujairah, Umm al-Qaiwain, and Ajman under one flag with Ras Al Khaimah joining them as the seventh representative in February 1972. He was respectfully admired for his responsive eagerness to put an effort for the substantial good of the country as he reflects great insights and perception. Following this successful accomplishment His Highness was introduced as the first president of the union on December 2nd 1971 (UAE Independence Day, 2014).

- Education in the UAE

In regards to the United Arab Emirates educational direction, as a goal to enhance the standards of people's lives, the country's leaders used its oil income. With all the development that the country is experiencing, the main precedence for social forming has been education. This is confirmed and emphasized by his highness Sheikh Zayed when he stated: "The real asset of any advanced nation is its people, especially the

educated ones, and the prosperity and success of the people are measured by the standards of their education" (Maitra, 2007).

Dating back to 1990, the UAE took part in UNESCO's "Education for All" instruction that aims to provide universal opportunity to primary education, attain gender equality, enhance standard of education services, decrease adult literacy and offer early childhood care. In 2010 the UAE together with 163 countries restated their duty and commitment to succeed in attaining universal education by the year 2015 (UNESCO, 2000).

Until today the country thrives to provide educational opportunities for its citizens such as the UAE vision 2021, which declares:

1- All Emiratis will have equal opportunity and access to first-rate education.
2- A progressive national curriculum will extend beyond rote learning to encompass critical thinking and practical abilities, as well as high scores on standard international examinations.
3- School dropouts rates will fall, university enrolments will rise, and more Emirates will climb higher up the ladder of learning into post-graduate education.
4- Those who leave school early will receive other forms of support such as vocational training (Ministry of Cabinet Affairs, 2011)

- UAE schooling system:

In this section we will go back to the first declaration made in the UAE as a unified country in 1970 to provide mass education.

The 1970's educational system is a 14-year education plan that is divided into 4 tiers:

Tiers	Age	Grade
1- Kindergarten	4-5	KG1/KG2
2- Primary	6-12	G1/G2/G3/G4/G5/G6
3- Preparatory	12-15	G7/G8/G9
4- Secondary	15-18	G10/G11/G12

(Ministry of Education, 2015)

The first UAE significant measure to attempt to give a universal form education was the UAE constitution and Federal law No.11 of 1972, which ensured that education was mandatory for the primary stage until 2012 when the law was modified to ensure that education was obligatory until grade 12. Hence, graduating at the age of 18 (National Qualification Authority, 2013).

There are two types of schools, public and private. 60% of the local Emirati students attend public schools, as it is free of charge for UAE citizens and funded by the government with a curriculum generated to be matching or relevant to the UAE's development and values. In comparison to the remaining 40% Emirati nationals who attend private schools, where registration is accessible for both Emirati's and foreigners, with fees that differ in each school (National Qualification Authority, 2013).

Thus, to ensure that government policies are being incorporated in schools, the Ministry of Education located educational zones in each Emirate such as The Abu Dhabi Education Council (ADEC) for Abu Dhabi and The Knowledge and Human Development Authority (KHDA) in Dubai and others, as they aim to work to measure and rate schools quality and standard of education (National Qualification Authority, 2013).

- Special needs in schools:

Due to the country's traditional and cultural belief that stresses the significant principle of social accountability to the needs of all the society members, the UAE has an immeasurable concern for the needs of people with special needs. For this reason, the UAE Federal Law No.29/2006 is the first law that defends and protects the rights of people with special needs. As for their education, it ensures them access to equal educational opportunities as well as offering them with special services that they may require, to enable their needs to be sufficiently satisfied in order to reach their maximum capabilities (Ministry of Education Special Needs Department, 2010).

The vision and mission of special education in the UAE, is to acknowledge that each student has unique abilities. Hence, offering a safe, caring, engaging, and a least

restrictive environment to allow the students to flourish and fully develop emotionally, intellectually, physically and socially. In addition to offering students with appropriate intervention programs and accompanying services in both public and private schools. It is essential to plan, implement and monitor the intervention programs very carefully. A future perspective of providing special needs students with the highest quality of international practices to prepare them to be useful and effective representatives in society (Belrehif, 2012).

The ministry of education in the UAE categorized what they authorize as being eligible candidates that require individualized provisions and intervention services. The special education categories include, specific learning disabilities, physical and health related disabilities, visual impairments, hearing impairment including deafness, speech and language disorders, autism spectrum disorder, emotional and behavioral disorder, intellectual disabilities, gifted and talented, multiple disabilities and developmental delay. However, students that undergo learning difficulties due to environmental factors, cultural factors, economic disadvantage, experienced academic fail are not qualified to receive intervention or support services from the school support system, they are considered as an exclusionary clause from people with special needs (Ministry of Education Special Needs Department, 2010).

2.8 SM in Dubai

Under the Federal Law No.29/2006 regarding rights of the people with special needs, it makes sure that people with special needs are no different than typically developed individuals when seeking access to enrollment in public or private educational institutions. Thus, ensuring an access to equal opportunities. However, students with special needs are eligible to receive suitable intervention and provision programs and related services such as modifying the curriculum, providing alternative easier strategies for teaching intentions or offering special classes to enable the students to bridge the gap between their disability and ability, and to learn by meeting their learning needs sufficiently in order to assist them in being able to fully participate in school needs (Ministry of Education Special Needs Department, 2010).

The law is backed up by the “School for All” which consists of general rules for the provision of special education programs services in public and private schools, that

was published by the UAE's Ministry of Education (MOE), special needs department. It consists of the philosophy, vision and mission for special needs, goals of MOE's special needs department, special needs categories, special needs programs and services, procedures for identification, rights and responsibilities of parents, teachers and educational institutes needs (Ministry of Education Special Needs Department, 2010).

However, under the special education categories it does not mention SM. But it does mention Emotional and Behavioral disorders. With my understanding of the condition, SM can be under that category. Because it is caused by excessive anxiety that effects the child's behavior by not speaking, and instead using behavioral inhibition or avoidance behavior to reduce their anxiety or fear. Moreover, it is an emotional disorder, since it lowers their self-esteem and confidence within themselves leading them to withdraw while expressing feelings of depression (Smith and Sluckin, n.d.).

In School for All, it recognizes Emotional and Behavioral disorders as it presents one or more of the described features below for an extended time to a point that it hinders the child's social and academic functioning:

- Distinct from intellectual, sensory, or health related issues, the child is incapable of studying or learning.
- Unable to create adequate connection with peers and teachers.
- Under normal situations, behaves and expresses feelings in an unsuitable manner.
- Persistent feelings of sadness.
- Reflects features of fear when faced with individual or school issues.

(Ministry of Education Special Needs Department, 2010).

The characteristics mentioned could relate to symptoms of a child suffering from SM, yet the disorder is not specifically stated. This might be due to a lack of awareness of the condition itself or its seriousness. It might also be because it is considered a rare condition, even though some research proved otherwise. Nevertheless, this is not a convincing reason to dismiss the recognition of a condition a child is suffering from,

consequently not considering them eligible to receive special educational services from educational institutes.

Included in "School for All", students suffering from Emotional and Behavioral disorders have the rights to receive positive interactions such as dealing with the students the teacher needs to be attentive and thoughtful by being understanding and sensitive towards the child. In addition to acknowledging the student's strengths and weaknesses, clarifying their set goals, ensuring peers are friendly, appreciate positive contributions, create a comfortable positively inclusive classroom environment and most importantly be patient with the overall student progress.

Yet, there are some positive interactions mentioned for Emotional and Behavioral disorders that will not help a student with SM, instead it would only increase their anxiety; an example is ensuring contact with students and positive contributions in group activities. A child with SM prefers to not speak or have contact with peers thus he or she is not expected to contribute especially when in group activities.

Fully implementing the theory of inclusion into action in the UAE is an unfinished project that is still being edited and developed. It needs to broaden its identification process and acknowledge the ranging diversity of categories in special education, such as including SM.

In an article called "SM: Finding Voice in Dubai" a Jewish clinician from New York talked about his trip to Dubai to treat a seven year old boy with SM (Selective Mutism: Finding Voice in Dubai, 2010). It concerned me to know that the family was seeking help from outside the country. But then this reflects that there might be a lack of understanding or awareness about the condition between clinicians in Dubai. Or if they are aware they may lack training or qualification to find the appropriate treatment program or intervention plan for the child's case.

Throughout the article he also mentioned that since the child's condition was very severe it hindered his ability to function in daily life aspects, primarily at school. As a reaction to the situation the parents "tried what they thought was every trick in the book to help him" (Selective Mutism: Finding Voice in Dubai, 2010). This shows that

they struggled to get access to appropriate treatment or an intervention program that would fit the child's required needs to be treated or improved, whether it was help from home, school or from clinicians.

Therefore, since he previously also treated "another child in Dubai" (Selective Mutism: Finding Voice in Dubai, 2010), emphasizing on the fact that another family formerly faced the same trouble of finding treatment for SM in Dubai, they found this Jewish clinician through a Google search and thus due to successfully treating their child he was later referred to the aforementioned family.

This emphasizes on the importance of conducting an in depth research on SM in general, as well as specifically in Dubai, to spread awareness of the condition that is usually misdiagnosed as shyness or a phase that the child will eventually overcome.

SM should be recognized in the "School for All" mandate describing the general rules for the provision of special education program services as a special needs condition that qualifies to receive special education services and provisions related to improving their social functioning and in some cases academics.

The development of including special needs in schools appropriately is, I believe, a written agreed upon law, but is still a work in progress in successfully implementing it in schools across the UAE and an increase of professional development and training for regular teachers, special needs teachers and other educators is significant in the development of special needs provisions and services within the country.

CHAPTER THREE

Methodology

3.1 Introduction

The purpose of this research study is to measure the level of awareness and attitudes of teachers and students towards an SM child. As well as discovering the conditions impact on a child's academic development. This will hopefully aid in spreading awareness that will allow parents and professionals to clear any doubts, myths or misconceptions they might have about the condition. With that knowledge it will enable them to be more attentive and understanding towards a selectively mute child as well as having access to the right and appropriate intervention plans to help with the child's treatment process.

The research participants are both teachers and students. Therefore, the study will follow quantitative methods of research through distributing hard copy surveys, since it is easier for the young student participants to fill out, and for teachers to get hold of without requiring them to be seated behind a screen where Internet connection is required.

Data collection took place in 10 randomly selected Private Primary Schools in Dubai. Even though 10 schools with a total of 20 participants from each school – teachers and students – totaling up to 200 participants, is a sufficient amount to fulfill the purpose of this research, the reason behind not including more schools to participate is because it is time consuming, schools approval to contribute in the survey takes time, some schools have policies that do not allow them to participate and some are simply too busy or are unwilling to participate.

3.2 Research Strategy

Survey Distribution
Duration: 20 minutes each.

The decision to use a survey was mainly because it is less time consuming and is able to reach a larger number of respondents. It also offers a wide diversity of data that can be accumulated as an illustration of their attitudes, opinions, beliefs, values or behaviors towards a certain matter.

- Teacher Surveys (Appendix 2):

10 surveys were distributed to 10 teachers in each school therefore totaling up to 100 teachers completing the survey. The teachers were randomly selected by the school primary principle. The only impact on the selection was the fact that the teachers were primary teachers that needed to have a minimum of 5 years of working experience as a teacher because of the amount of knowledge and skills he or she will have as well as being more able to notice or identify any uncommon or untypical behavior and are aware of students with different abilities, as well as knowing of strategies on how to help students overcome their obstacles compared to a newly assigned teacher.

The survey included 11 questions that covered numerous areas such as if they are aware of the condition, or what they think it is, how does it make them feel as a teacher, what they think is the reason behind the condition, describing the selectively mute child's characteristics, how it affects their competence in teaching, the conditions negative impact on the teacher and learner, does it have an impact on the child's academics with an explanation, and whether they were or weren't able to help. The overall outcome of the answers will enable the measurement of their level of awareness about the condition, their attitudes towards students who suffer from SM and whether or not it is believed to have an impact on the student's academic development.

However, due to their busy schedule, teachers were not able to be grouped in the same place as they answered the survey individually, teachers were asked to complete the survey in their free time and then submit it to the school principle during the day. Thus, taking a longer time to collect them all.

- Student Surveys (Appendix 1):

10 surveys were distributed to 10 students in each school therefore totaling up to 100 students completing the survey. The students were randomly selected from grade 6. The reason for choosing grade 6 students is because they are the highest grade level in primary school, therefore, they are more informative and elaborative compared to students in grade 1.

The survey intended to discover the extent to which typically developed children are exposed to selectively mute children, as this will help us know the rarity or commonality of SM in schools nowadays. The questions also covered how they feel towards the selectively mute child, what they think is the causation, a description of the characteristic behavior in the classroom, an opinion on the impact of SM on the child's academic standing and how they helped or think they can help.

The students will be given 15 minutes to answer 10 questions. It is an appropriate amount of time to allow the child to answer the questions with no rush. The questions will be read to the students in 2 groups having 5 in each group because this will allow the group to be more focused as well as allowing students to ask for help reading or clarifying any question to ensure adequate responses. Their answers will help us measure their level of awareness, attitudes and beliefs regarding its impact of academic development and thoughts towards the condition from a viewpoint of a typically developed peer.

3.3 Data Storage and Analysis

The data collected from the method that was used in conducting the study. As soon as a survey was completed in a school, the results were immediately recorded to avoid the loss of any data. The outcomes were divided into categories, thus using a tally chart to tally up the category every time a respondent gave the same answer. Then the categories were represented into percentages. This simple format will ease the process of analysis because the results are clearly presented.

3.4 Ethics

With respect to the importance of ethics in research, an official letter from the University was written to the schools to ensure them that this study is for the purpose of my masters' degree. Some schools were willing to participate in the survey, while others refused to participate due to school policies.

The school was verbally informed that the confidentiality of the school name as well as the identity of both student and teacher participants would not be revealed in the research. Numbers such as school 1, school 2, etc. identified schools during data collection. On the other hand, participants were given alias's to ensure their anonymity and safety and in accordance with our agreement, thus allowing them to feel more comfortable to open up and be more honest when giving answers.

3.5 Limitations and Challenges

In every research study there are some limitations and challenges. In this case, the table below mentions them:

Limitations	Challenges
The survey population was enough to provide an overall picture to reflect awareness levels and attitudes, but not enough to generalize or represent the whole of Dubai.	Rescheduling student survey distribution more than once due to the schools busy schedules, some were willing more than others, yet all participated.
Due to the survey being only in English, Arabic speaking teachers were not able to participate since they were not competent in the language, therefore, limiting the diversity of participants able to complete the survey.	Finding teachers in the school who were ready to participate was time consuming and could take up to three weeks to receive the completed survey with justifying reasons such as they have too much grading to do or busy with back to back lessons.
Using paper based - hard copies - for my survey, is more time consuming compared to using an online survey.	Some students and teachers gave irrelevant responses to the questions, or simply left them blank. This makes it

	hard to asses their level of awareness, attitudes or opinions regarding the conditions impact towards an SM child's academic development.

CHAPTER FOUR

Results and Discussion

To view all the survey results for teachers, it will be available in (Appendix 4), while students' results are in (Appendix 5).

4.1 Research Question 1

To what extent are teachers, students and parents aware of SM?

- Teacher Survey (Appendix 4)

This section will focus on questions 1,2 and 4 from the teachers survey as they measure the teachers' level of awareness regarding SM.

Question 1 of the survey "What is the condition called when a person normally capable of speech, but does not speak in specific places (school), or to specific people (teachers/peers)?" found that 23% of the teachers that participated in the survey were unaware of SM by selecting "I don't know", while 26% answered "I am not sure". On the other hand, the majority 51% answered, "I know the condition." However, from the 51% only 30% gave the correct answer as "Selective Mutism", while the rest 21% gave incorrect answers such as; "introvert," "autistic," "shy," "personality disorder," "inferiority complex," "lack of confidence," "afraid, special needs," "speech phobia," "stage fright," "communication problem," "inability to talk" or child with "unusual behaviors."

This gives us a total of 70% (including the following: "I don't know," "I am not sure" and who said "I know the condition" but gave the incorrect answer) of teachers who are unaware of SM, which is a big problem because if the condition is not acknowledged and is left untreated it may last for years and the older they get the longer it takes to overcome their anxiety. Thereby, not allowing them to function normally in their daily lives (Bergman et al., 2002).

Question 2 of the survey "In your years of experience as a teacher, did you have a student that found it difficult to communicate with you (teacher), or with the peers in the classroom?" The majority 80% of the teachers answered "Yes" while the minority

of 20% answered “No.” It is not unusual to see that 80% of the teachers said that they once had a child who found it difficult to communicate with both teachers and peers, because teachers would be associating it to a broad spectrum of conditions that hinder speech, such as those mentioned by the 21% in question 1 who presented multiple reasons. Whereas 30% in question 1 identified the condition as SM.

The concern becomes that the 70% from question 1 and the 80% in question 2, might have SM, but remain dismissed or misdiagnosed as another condition which means they will not be receiving the correct treatment to overcome the difficulty, therefore it persists as they grow older. Consequently, awareness is a significant part in ensuring that all SM students are attended to appropriately and for teachers and professionals to be knowledgeable and qualified to provide sufficient services to satisfy their needs.

Question 4 of the survey “What do you think is the reason behind the child’s inability to speak?” From the 100 teachers that answered, there were a total of 48 answers as some teachers gave the same answer. However, from the 48 responses some were removed due to irrelevance, some gave signs of SM not reasons, others gave the same answer but using a different synonym, and others were grouped into one due to the similarity in meaning. Thus, this resulted into 17 reasons for SM, it does not necessarily mean they are all correct responses however. The reasons included; “family dysfunction,” “traumatic experiences,” “social problems,” “personality insecurities,” “bullying,” “language problems,” “immigrant family background,” “autistic characteristic,” “anxiety disorder,” “psychological disorder,” “genetic reasons,” “oppositional behavior,” “coping mechanism to stress,” “deafness,” “lack of interest,” “emotional disorder” and finally “shyness.”

The top 3 reasons included firstly; 28% “personality insecurities” such as lack of confidence, low self esteem, self conscious, ashamed, afraid to talk then be laughed at by peers as well as feeling socially unaccepted, which is not unusual for a child who is struggling to speak, since there are significant impairments in the child’s life which does not allow them to function normally in social situations or settings.

Secondly, 18% “family dysfunction,” because not having healthy family relationships, marital status, appropriate parenting styles or sufficient monetary

income to support the family, will give the child the impression that anything outside the immediate family is unsafe or not trusted, this is reflected in their silence to secure family secrets. These are just theories but research suggests that there is no evidence to support this causal factor because a research conducted to measure the level of family dysfunction and other family characteristics showed no difference between parents with or without a child with SM (McHolm et al., 2005).

The third top reason was 16% "shyness." Most parents and teachers say that this is just a phase that the child will eventually outgrow without taking possible treatment actions into consideration. Having a shy disposition or family history of shyness makes the child feel shy when being asked to speak in public (McHolm et al., 2005). This causes the child in some cases to panic while anxiety levels increase. Thus, by being overwhelmed with anxiety, the child chooses to remain silent in order to cope with the situation and reduce the anxiety level by displaying behavioral inhabitation (Camposano, 2011).

There is no clear-cut definite reason approved by scientists in research studies as to what causes SM. However, there are different assumptions or factors that may conceivably have an effect on the appearance of SM, or be present alongside the condition (Camposano, 2011).

- Student Survey (Appendix 5)

This section will focus on questions 1,2,4,6 and 7 of the student's survey, as they will answer the question regarding the students' level of awareness about SM.

In question 1, "do you have a friend, or know someone who does not speak in the classroom at all?" the majority 88% answered "yes" while the minority 12% answered "no." This shows that it is common for students to see or know someone who has this condition among their peers in the classroom. While on the other hand, they do not necessarily mean they know the condition is called selective mutism, as much as simply knowing that this person has the flu.

In question 2, “does that person speak normally outside school?” 50% answered “yes”, 7% answered “no” and 43% answered, “I don’t know.” The students that answered “yes” most probably know the SM student quite closely, because the SM child will only speak normally if they felt comfortable being with them to allow them to be seen in their less anxious state within their familiar settings, unlike in school. Otherwise, they may know that fact from a mutual friend who is in close contact with the SM student (Chansky, 2004).

In question 4, “why do you think this person is unable to speak in the classroom, or in school?” there were 29 responses. However, the majority 55% answered, “shy.” It was previously discussed because it was also the third top reason on what teachers thought the reason was behind the child’s inability to speak.

Among the responses, there were inappropriate responses such as “does not use their mind” and “robotic.” The SM students without a doubt are capable of using their mind like any other typically developed child in the classroom; their academic development will depend on their level of intelligence (Cunningham et al., 2004). Also, it’s their high level of anxiety that stands as an obstacle that hinders their potential to function normally, thus freeze, or use behavioral inhabitation or avoidance behavior as a coping mechanism which in turn may display them as having slow motion movements (Smith and Sluckin, n.d.). However, if their peers are thinking of them in such terms then we are definitely facing a larger problem than simply awareness, it could lead into discrimination and right out verbal abuse.

Therefore, some stated it might be due to the fact that they are “bullied.” Although, there is insufficient research to generalize or state that SM children are more liable to be bullied or teased. However, with the available limited research it shows that at least 5% of the SM populations are victims of bullying (Kumpulainen et al., 1998).

On April 16, 2007 a 23-year-old South Korean boy was responsible for mass murder in the campus of Virginia Polytechnic Institute and State University, in Blacksburg, United States of America (USA). He then committed suicide by shooting himself on the same day (Blanco, n.d.). He was formally diagnosed with SM in year 8, when he stopped speaking at home or in school. As a result, he received medication, therapy

and was excused for participating orally during class presentation or group discussions. He was described as “awkward,” “introvert,” “lonely” and “insecure” as he wears his sunglasses even when indoors. It was told that he “wouldn’t talk at all,” “didn’t say much,” “didn’t mix with other children,” “would not respond if someone greeted him” and “lacked eye contact” (Blanco, n.d.).

Unfortunately, he was bullied due to his mutism and was not receiving appropriate treatment approaches from some of his teachers such as threatening to fail him if he did not speak, for instance he was forced to read out loud in the class, a peer described as strange and unusual “like he had something in his mouth” as his peers laughed, pointed and shouted “go back to china” when he is actually Korean. The anger built up within him with no way of verbal defensive expression (O'Connell and Moldan, 2013).

SM children desire to speak, want to have friends, cant reach out and are unable to connect. He described it as “the words are locked behind doors, and I don’t have the key.” Therefore, appropriate early intervention is crucial to protect individuals from themselves and others, as he wrote on his bedroom wall the lyrics of a song “teach me to speak, teach me how to share, teach me where to go” (O'Connell and Moldan, 2013).

In question 6, “how do they ask the teacher for permission or for help in the classroom?” 34% “they don’t, instead they stay quiet,” 26% answered, “they use non verbal communication” and 40% answered “other” by stating their response. There were a total of 9 responses.

It is not surprising that most SM children are seen to be “quiet” and not say anything because they feel very anxious or fear to speak in the classroom. Therefore, they try to avoid any attention coming their way by staying silent as a coping mechanism (Kearney and Vecchio, 2007). However, it is at least advantageous that some students use non-verbal communication as an alternative to speaking rather than cutting any form of communication with teachers or peers. At least this way, the teacher as well as the peers can have some form of communication with the child to get to understand the child better, and learn how to satisfy their needs.

There are some students who answered otherwise, such as the student "occasionally asks," "asks in lowest voice," "writes on paper," "whispers in teachers ears," "tells a friend to speak for them," "uses sign language," "raises their hand and waits for permission," "writes on their computer" or "does not show interest in class."

Students mostly said that the SM child "tells a friend to speak for them." It is common for a fellow member of the class to speak in favor of the child with SM. Particular classmates in many cases appoint themselves as a spokesperson, sometimes notifying new classroom members that the child does not speak. This is in view of the fact that most students especially the younger graders undertake a nurturing and caregiving role towards their SM peer (McHolm et al., 2005). In this case, it may work in the SM child's advantage to feel accepted and cared for, particularly by children of the same age group. Thus, it is a comfortable classroom environment for the SM child, as they don't feel the pressure of speaking which will eventually hopefully work towards reducing their anxiety level.

However, some mention that the SM child "raises their hand and waits for permission" this an unusual behavior for a child who finds it difficult or scary to speak in social situations such as in the classroom in front of all their classmates. As they in actuality try to do the opposite by staying low key. This shows that there is a lack of awareness about SM, the students must have been speaking about a child with an introvert or shy personality but definitely not SM.

In question 7, "does he/she have any friends that they can talk to outside the classroom?" the majority 59% answered "no." This can in fact be correct because SM can impede the child's ability to perform the ingenious skills of interacting and creating relationships, since they do not speak in social situations. Not only that, but some may be physically restricted in the fact that they seem frozen in their motion or are considered unwilling participants in-group activities (Cunningham et al., 2004). Also, some are self-conscious to the extent that they feel uncomfortable eating in front of others or even going to the school bathroom (McHolm et al., 2005). With the lack of social skills forming friendships may be an issue. Then again, there are SM children that feel comfortable participating and interacting as long as speaking is not

needed. In that case, they are able to make friends with at least a small group of classmates. On the other hand, the minority 13% answered, “don’t know” and the rest 28% answered “yes”. Therefore, this shows that the level of inhabitation can differ substantially depending on the individual case.

4.2 Research Question 2

What is the attitude of teachers, students and parents towards a selectively mute child?

- Teacher Survey (Appendix 4)

This section will focus on questions 3 and 5 from the teachers survey as the questions judge the teachers’ attitudes towards SM.

Question 3 of the survey is “how did it make you feel as a teacher” to have a student that was struggling to communicate with you as his teacher, or with peers in the classroom. There were 28 different responses. Again, some answers were the same, similar or irrelevant which narrowed it down to 16 responses. Since we are measuring the teachers’ attitudes, the responses were divided into 3 categories, consisting of: positive, negative, and neutral.

The majority of 40% were positive such as; “concerned,” “capable,” “determined,” “responsible,” “curious” and “empathetic.” While 32% were neutral such as feeling; “challenged,” “helpless,” “stressed” and “scared.” The 28% left were negative responses by stating they felt “frustrated,” “uncomfortable,” “pity,” “angry,” “annoyed” and “disappointed.”

Fortunately, there were more positive than negative attitudes towards a student with SM. It showed that the teachers were willing to work on helping the child overcome the condition. It showed that teachers believe that it is their duty and responsibility to attend to the student’s needs, especially by feeling empathy and by understanding their feelings through showing acceptance. It is not wrong to feel “challenged,” “helpless,” “stressed” or “scared,” as these are normal feelings any teacher may experience when dealing with a new or difficult case with a student. However, what they do about it is what will determine the students’ access to help.

On the other hand, the negative responses, questions the teacher's capability in fulfilling her role as an educator or mentor to the younger future generations. If the teacher is not accepting the classrooms diversity, and the different students academic and social abilities, then she is an unqualified teacher at this time, as all government support is moving towards the inclusion of children with special needs in mainstream schools among typically developed students.

Question 5 of the survey "what are the characteristics of the child?" there were 45 different responses. Some characteristics contrasted the other for example; "well behaved" and "misbehaves," "academically weak" and "academically good standing" or "calm" and "aggressive." This is not necessarily to say that only one is correct but all depends on the unique individual case and what the teacher believes to see from the student.

The top 5 characteristics were 14% "shy," 13% "withdrawn," 12% "quiet," 8% "lonely," and 6% "avoids eye contact." As mentioned previously a child suffering from SM may have shy temperaments or a family history of shyness, which leads them to feel anxious resulting in the preference of silence, which displays them as being quiet (McHolm et al., 2005). They also appear to be lonely as they are unable to socialize with other children, so for instance they spend recess wandering around the playground alone. Another known characteristic is that they seem to be withdrawn and avoid eye contact; this is because they are displaying avoidance behavior to escape from socializing with other children or teachers because they fear social embarrassment or feel overwhelmed by anxiety that disables them from speaking (Camposano, 2011).

There were some terminologies used to describe the SM student characteristics that were inappropriate or inaccurate, for instance the child is "irresponsible." All kids are born with no responsibilities and the way they behave towards cause and effect is all by instinct (Lehman, n.d.). Therefore, parents and teachers must encourage responsibility. But in the case of SM children they may appear irresponsible or uninterested but in actuality they are struggling as they cope with their anxiety.

Another characteristic mentioned was “negative” it is a very vague description of an SM child and “not normal.” If they understood the condition they would realize that SM children are able to function and talk normally at home or in familiar settings where they feel comfortable but only find it difficult to talk in specific social settings and to specific people due to their anxiety levels being high. Also “slow” is unclear if they meant slow learning then they are generalizing that all SM students are slow learners which is incorrect (Stanley, n.d.), and if they meant slow as in motion wise, then this is another form of coping mechanism where the child freezes in anxiety provoking situations to reduce the overwhelming feeling (Vecchio and Kearney, 2005).

Others said that the child “only speaks in the mother tongue” which means that the child is not mute, instead the child is either incompetent or is facing difficulties in speaking the required language in the classroom. Surprisingly, a teacher mentioned that the child “thinks it’s cool” not to speak, which shows how naïve and lack of experience or knowledge the teacher has regarding the condition in order for her to react with a positive attitude towards it.

- Student Survey (Appendix 5)

This section will focus on questions 3 and 5 of the student’s survey, as they will answer the question regarding students’ attitudes towards SM.

In question 3 of the survey “How does that make you feel” to have a friend, or know someone that does not speak in the classroom at all. There were 23 different responses, which included the typically developed students feeling “sorry for them,” “curious,” “sad,” “want to help,” “worried,” “felt bad” and “want to befriend” them. These are considered positive attitudes from their peers because it shows empathy and a willingness to assist in making them feel better and overcome their condition.

There were also opinions that expressed what they felt towards the SM child such as “annoyed when not spoken to,” “uncomfortable being around them,” as well as the fact that they realize that “they are lonely” as it is “hard not to talk” them.

However, it was surprising to find out that there are some students that felt "privileged," "happy" and "glad" this is not to say that this is a positive or negative attitude towards SM children, but shows that they realize that SM children are struggling everyday as they find it difficult to communicate or express their feelings with the people around them in school. It also shows that they appreciate their capabilities, thus learn to be thankful.

Also, some students felt that it is "their opinion" not to talk and that they are "wasting their time." This shows lack of awareness and knowledge about the condition as well as how it critically affects the child's ability to function appropriately in social settings. Therefore, the child does not feel empathetic or accepting towards their SM peer.

Finally, there were some negative attitudes as well as irrelevant or inappropriate responses which included them feeling "weird," "bored," "normal," "quiet," "irritated," "feels disgusted" and "don't know." This shows that they are still young students exhibiting their childlike nature and that they are not at the maturity level to understand the seriousness of this condition. They reflect their naivety and innocence.

In question 5 of the survey "Describe this person's behavior in the classroom or in school?" there were 30 different responses that were categorized into 3 groups: positive, negative and neutral behaviors.

There were 12 positive behaviors which included "well behaved," "friendly," "polite," "kind," "good listener," "follows the rules," "fine," "nice," "good," "good academic standing," "not disruptive" and "clever."

There were equally 12 negative behaviors which included "forgets homework," "angry," "prefers to be alone," "nervous," "awkward," "disobedient," "doesn't participate," "scared," "not speaking," "language difficulties," "doesn't do anything" and "not moving."

Finally, there were five neutral behaviors, which included "quiet," "occasionally speaks quietly," "shy," "uses non verbal communication" and "loves reading in the

lesson." There was one response that cannot be related to the behavior of an SM child is "talks outside class" because it is known that SM children do not stay silent only in the class but in school or any social setting that they feel uncomfortable being in.

After going through all the three categories where the students described their SM peers, it could safely be said that there are no extreme negative attitudes towards SM. The reassuring part is that the majority 62% of the children retain feelings of compassion and a desire to support and help their fellow classmates. Children's attitude is quickly influenced and altered, therefore maintaining this level of compassion and affection towards their fellow classmates is a responsibility that falls on both teachers and parents to set an example on how to treat and interact with children of all kinds of special needs and not simply SM.

4.3 Research Question 3

Does SM have an impact on the child's academic progress?

- Teacher Survey (Appendix 4)

This section will focus on questions 6,7,8,9 and 10 of the teacher's survey, as they will answer the question to help discover whether SM affects student's academic development.

Question 6 of the survey "Did that student disrupt or have an affect on your ability to teach in the classroom?" the minority of 24% answered "yes" while the majority of 76% answered "no." The teachers in question 7 "if you answered yes to question 6, please explain" gave reasons to the difficulties they were facing in the classroom due to the presence of the SM child. There were 14 responses; some were grouped together due to similarity, while some were removed due to irrelevance. Therefore, clearing out to a list of 9 responses, which included, 20% said the student "requires more attention than other students," 16% said its due to "not having any oral participation," 16% "needs separate instructions to complete work," 8% "distracts other students," 4% "answers tasks using mother tongue," 12% "uses non verbal cues," 4% "only spoke to teacher," 8% "not active" and 12% displays "oppositional behavior."

The student with SM may in some cases “require more attention” because they “struggle to speak or participate orally.” Therefore, by giving them “separate instruction” to encourage and ensure the student gets work done. But then again, this may not work to the teachers favor due to the fact that the SM student does not feel comfortable being the center of attention. Thus instead using “non-verbal cues” such as using eye contact, facial expression and body language, taking away focus for a few moments from the whole class to satisfy that student’s individual needs (Cline and Baldwin, 2004). As well as allowing the student to feel more comfortable as they are not being asked to speak.

SM children do not “distract other students” because they try to avoid any form of interaction with individuals in uncomfortable settings such as the classroom. Thus, they may seem to be “not active” when compared to other peers in the classroom (Vecchio and Kearney, 2005). But they may display “oppositional behavior” when trying to cope in situations that cause distress in efforts to avoid that situation (Diliberto and Kearney, 2016). Therefore, it is best to not force or push them to speak or answer verbally if they refuse once.

It’s interesting to know that one of the responses was “answers tasks using mother tongue” its understandable to see how this can affect the teachers level of competence if she does not understand the students language which means there is a communication barrier that hampers the students academic development. But in this case, the child may be facing a language difficulty that does not allow him or her to communicate with peers and teachers, which leads to a misdiagnosis of SM.

Finally, the responses that said “only spoke to teacher” should be viewed as a positive indication, the child may feel safe and comfortable to talk to the teacher since it is her responsibility now to put an effort to take the next step in creating the appropriate relationship and right environment to help reduce the child’s anxiety. Which will eventually result in the goal of helping the child to gradually speak in the classroom.

Question 8 of the survey “what is the negative role that this condition played towards you as a teacher and the child as a learner?” There were equally 19 responses each to the negative role of the condition towards the teacher and learner. However, the

answer that most teachers agreed upon was affecting them had been: “difficult to asses learning” while it was: “falling behind academically” for the learner.

There is no evidence from research that states that SM notably impedes or is a hindrance to the students’ academic development for them to be “falling behind academically” (Stanley, n.d.). They exhibit learning abilities that are compatible with their intellectual abilities and their test results resemble those of their peers. They are also able to display nonverbal behaviors that are significant to academic achievements, such as following instructions and directions, cope with transitions between activities, completing assignments without delay and pay no attention to peer distractions. In addition to the fact that, SM children display less disruptive acting out behaviors compared to their peers (McHolm et al., 2005).

However, teachers struggle as they find it “difficult to asses learning” and knowledge of the SM student when it is related to speaking such as reading fluency and oral presentation. On that note, teachers should put in place flexible and creative assessment methods that will cater the child to reveal their veritable potential (McHolm et al., 2005). It is also important to take into consideration the fact that oral skill requirements increase as the child goes to a higher-grade level. Modifications to class lessons are not obligatory but minor changes to particular activities related to speaking are necessary (Cunningham et al., 2004). Therefore, planning and finding solutions and alternatives is essential to help overcome the child’s speaking difficulties if they are not ready yet. This will result in decreasing the child’s anxiety and increasing their general confidence in the classroom.

Question 9 of the survey “In your experience of having this child in your classroom, does this condition have a positive or negative effect on the child’s academic ability?” The majority of 79% said “negative,” while the minority of 21% said “positive” with an explanation for their choices in question 10.

In question 10 “Whether you choose positive or negative, please give an explanation.” The positive responses were that the student is “learning and improving,” “learning is not affected at all,” “intelligence,” “managed with intervention treatment plans” and “strength outweighs weaknesses.” Another two responses mentioned but were vague,

and required further clarification such as: “helped him understand the value of participation,” but what if they are aware of the value, but it is out of their control due to the overwhelming anxiety. The other response: “will help students be patient and help each other” is debatable.

Moving to the negative responses, which included “ineffective communication hampers learning,” “face problems progressing academically and socially,” “does not fully participate in classroom,” “slow learner,” “low results” and “difficulty in assessing child’s performance” were previously discussed in question 8 regarding the SM child’s academic development. Also, SM “impeded their communication skills,” and “does not ask for help,” which is quite obvious because the child suffers from SM, making it difficult for the student to verbally communicate in the classroom.

A situation where the SM student “lacks support of peers” and “no teacher-student relationship” makes it “hard to deal with” the student is a case wherein the teacher lacks knowledge or support towards the condition. The responses that said the child is “not interested in learning,” “not learning” and “no work done” may be because the teaching method used is not to their favor as they may require verbal speaking, thus anxiety overweighs their ability to fully participate, this maybe reflected as lack of interest.

The final response was because of SM “academic development is effected” in the point of view of teachers, thus the student “requires help from special educational services.” As explained previously, learning is not hampered due to communication difficulty so special educational services are not needed unless offered to enhance their social development by helping to lower the child’s anxiety or fear of speaking, improve self-esteem and self-confidence to result in the student feeling safe, comfortable and confident in the school environment.

- Student Survey (Appendix 5)

This section will focus on questions 8 and 9 of the students' survey, as they will answer the question to discover whether SM affects student’s academic development.

In question 8 of the survey “Since they do not speak in the classroom, do you think it has a positive or negative effect on their academics?” the majority 77% said “negative,” while the minority 23% said “positive.”

However, in question 9 of the survey “Based on your answer for question 8, give a reason.” There were 31 different responses. Surprisingly, after grouping the responses into: positive, negative and neutral. The majority 55% gave “negative” responses, 26% were “neutral” and the minority 19% were “positive.”

The students’ reasons for viewing SM as having a “positive” effect on their academics justified their answers by stating that “it helps the student realize the importance of communication,” they are “not disruptive,” “well behaved” and “doesn’t get in trouble” in the classroom. Since they do not speak they are “able to listen” more carefully and focus on the lesson consequently having “good academic standing.” But the top three reasons were 29% “able to listen,” 24% learn the “importance of communication” and 19% “not disruptive.”

On the other hand, the students’ reasons for viewing SM as having a “negative” effect on their academics justified their answers by stating that some have “language difficulties,” achieve “low grades,” “no participating” in the classroom, “no group work,” “can’t ask for help,” as a result they are “not learning,” they have a “problem making friends” therefore they “will be alone,” “doesn’t follow the rules,” “doesn’t talk” thus are seen to be “very quiet,” “doesn’t understand,” “not mentally present,” “cant concentrate,” “forgetful,” “afraid of failure” and present “incomplete work” to the teacher. But the top three reasons were 20% “cant ask for help,” 14% “low grades” and 12% “not participating.”

These are just students’ opinions that do not necessarily mean that they are all correct. One important thing can be taken away from these differing responses is the existence of differing levels of SM and/or other learning difficulties among the students that plays a role in deciding their academic development. In addition to the fact that the responding students might be evaluating the said SM child based on a comparison to themselves and thus produce differing responses.

4.4 Research Question 4

To what extent were the teachers and students recommendations in dealing with an SM child useful?

This section aimed to measure the level of adequacy and applicability of the students and teachers suggestions on how to help an SM child. It is essential to the growth of this field and its success that we as researchers benefit from the experience of both teachers and students who interact with the SM child on a daily basis. Regardless of the amount of researched studies and cases, no number of therapeutic interventions provided from external sources -outside school- can successfully benefit the child if they were not provided in the said environment i.e. school. Therefore, it is paramount to consider the first hand experiences of teachers and students in dealing with an SM child in order to achieve long-term benefits.

- Teacher Survey (Appendix 4)

This section will focus on question 11 of the teachers' survey. It will reveal different intervention plans, recommended by teachers based on their experience on what helped or believe could help a child with SM.

In question 11 of the survey "What was your intervention plan to help this child? Give a reason," the majority 64% answered: "I was able to help" while the minority 36% answered: "I was not able to help."

By looking at the list of responses given by the teachers that believe they managed to help the SM child, some were grouped together as they represented the same thing, while some were removed, as they were unclear in their meaning.

Therefore, the different strategies that the teachers suggested were helpful while having an SM student in the classroom included: "spend time to create rapport," "create a safe classroom environment," "pair with competent student," "curriculum modification," "show tenderness, kindness and love," "avoid segregation," "build self-esteem," "pulled out for special educational services," "use non verbal communication," "provide assignment in student preferred language," "family therapy," "speech and language therapy," "behavioral therapy," "play therapy,"

“focus on social development,” “use different learning styles,” “positive reinforcement” and “extra curricular activities.”

The majority 31% answered “spend time to create rapport” is what most used as intervention plan to help the child. It is important to have a close teacher/student relationship to build trust and understand the student’s feelings or ideas to enhance healthy communication (Howells, 2014). However, it might not be as easy with an SM child. Therefore, alternatively, you can talk around the child without using their name, no supposition to speak or not, play without interrogating open ended questions, acknowledge gestures as if they are speaking and use untimed non verbal tasks (Winder, 2015).

Nevertheless, just because the teachers suggested it helped them with their student, does not necessarily mean they are all supported by research. However, some teachers mentioned otherwise, they were unable to help the student due to the fact that they had “no time to intervene alone properly in a large classroom,” “no proper guidance for appropriate intervention” and “no guidance from the school itself.”

This raises a concern because it emphasizes the fact that there are schools that fail to support their teachers with required guidance to appropriately intervene and help the student overcome their struggle to communicate. In this case SM students are victimized unfortunately, because an unqualified educator teaches them, as a result, their condition will persist and worsen, as they get older (Winder, 2015). It is a responsibility of the school to address such shortcomings and become active in the process of qualifying and updating their teachers with the necessary skills and techniques in handling such cases.

- Students Survey (Appendix 5)

This section will focus on question 10 of the student survey. It will reveal students recommendation on how they can help their SM peer.

In question 10 “How do you think you can help?” there were 20 different responses which included: “help them feel less shy,” “tell them to improve,” “find out the problem,” “help them follow rules,” “help them in studies,” “try to make them

social," "encourage them to speak," "explain why its negative behavior," "help with teachers issues," "give helpful advise," "communicate through writing," "create chatty atmosphere," "spend time with them," "help them in general" or "I don't know."

Some gave similar responses such as "be their friend" or "help them make friends" and "help in participation to build confidence" or "giving them confidence." However, the majority 21% said "try to communicate with them" which is the most evident reason reflected by the struggle with SM.

The students had some good input on how they think they can help. It showed that they were willing to help, but in the end they are students from the same age group, that are not qualified to provide the right or appropriate treatment for their SM peer. Nonetheless, it is important to involve students in the process of treating an SM child, because they are a critical part of his life and development. Once the children realize the importance of helping and supporting their peer, the SM child's trust and confidence in them will slowly develop allowing them to gradually communicate and feel more comfortable in their surroundings. Such positive attitude from the students is encouraging and hopeful, this kind of thinking shows the students are quite accepting and tolerable of others.

CHAPTER FIVE

Conclusion

One of the most common assumptions that both teachers and students made regarding a child's difficulty to speak was shyness. Therefore, it is viewed as a phase that the child will eventually overcome and outgrow (Stanley, n.d.). The insignificance attached to this characteristic becomes problematic, as it could be a misdiagnosis of a much larger condition i.e. selective mutism.

In order for us to achieve successful inclusion in mainstream schools, our primary focus must be raising awareness amongst teachers and students. Although the research showed that there were teachers who specifically stated the condition as being selective mutism, while some assumed it is another condition and others simply did not identify any communication difficulty, it is critical for teachers to remain constantly up to date and aware of all disorders, as they are the first step towards the child's treatment. Since the teacher's ability to recognize and acknowledge the condition would lead to early intervention, hence resulting in a speedy cure. The earlier the condition is dealt with the lower its chances of persistence and development (Harper, 2015). The least that could be achieved from awareness amongst teachers would be avoiding their mistreatment and ignorance in dealing with an SM child, which in itself could be a blessing rather than ill-treating the child and worsening their social performance.

On the other hand, none of the students were able to identify the condition as SM, nor was it expected of them. However, it remains equally important to draw their attention and bring to their awareness their integral role in helping their SM peer towards a successful treatment. Some of the advantages of raising awareness among students begin with creating an environment infused with acceptance and compassion, working towards making it the least restrictive environment for an SM child. Making typically developed children aware and understand an SM child's level of social anxiety, all the while encouraging them to help and support their SM peer rather than pointing out their shortcomings and inabilities, will have a positive impact on the child's comfort level in the classroom. Furthermore, with awareness and acceptance the students will

be more empathetic and ready to befriend their SM peers, thereby finding alternatives to verbal communication such as non-verbal communication. Thus, not pressuring the child to leave their comfort zone, if they are not yet prepared to do so.

With regards to attitude, majority of both teachers and students presented positive reactions. Among these feelings were indications that reflected their willingness to ease and lessen the SM child's social difficulties such as feeling "concern," "capable," "responsible," "want to help," and "worried." It also reflects their belief and faith in the SM child's capabilities and potential to improve and perform as any typically developed student. In other words, having a positive attitude towards an SM child can boost their self-esteem and lower their anxiety thereby ensuing relationships built on trust hence expanding their comfort zone (Harper, 2015). It is important to point out that negative feelings such as "frustrated," "disappointed" and "angry" are not to be judged, however, expressing them or acting upon them may have dire consequences.

Moving on to the SM child's academic development, both teachers and students believed that it has a negative impact on their academics. However, there is no available evidence that supports this claim (McHolm et al., 2005), this is not to say that their evaluation is invalid, nonetheless, it becomes questionable as it is unclear that their answers were specifically regarding SM. In fact, research has suggested that SM children's intellectual abilities are not affected by their existing condition, thus having the ability to perform similarly to their peers (Stanley, n.d.).

In conclusion, this research has brought to our attention that SM has been somewhat neglected compared to other disorders such as Autism and Attention Deficit Hyperactive Disorder. Thereby, assigned less seriousness because its symptoms are not as pronounced, thus dismissing it as mere shyness or other personality insecurities that affect their social functioning. At the end, it is only hoped that this research has cleared any doubts or myths as well as being able to amplify the importance of this condition and highlighting the value of cooperation amongst teachers and students towards an SM child's successful treatment.

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APPENDIX 1

Letter from University

الجامعة البريطانية في دبي
The British University in Dubai
www.buid.ac.ae

5 October 2015

To Whom It May Concern

This is to certify that Ms Hessa Khalifa Al Agroobi with Student ID Number 2013201002 is a registered part-time student on the Master of Education (following the pathway in Special and Inclusive Education) programme in The British University in Dubai, from January 2014.

Ms Al Agroobi is currently working on a dissertation as part of the programme requirements. She is required to gather data by conducting a questionnaire surveys, interviews and classroom observation. Any support provided to her in this regard will be highly appreciated.

This letter is issued on Ms Al Agroobi's request.

Yours sincerely,

Amer Alaya
Head of Student Administration

الجامعة البريطانية في دبي
إدارة الطلبة
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APPENDIX 2

Teacher Survey

1- What is the condition called when a person normally capable of speech, but does not speak in specific places (school), or to specific people (teachers/peers)?

I do not know	
I am not sure	
I know the condition is called:	

2- In your years of experience as a teacher, did you have a student that found it difficult to communicate with you (teacher), or with peers in the classroom?

Yes	
No	

3- How did that make you feel as a teacher?

4- What do you think is the reason behind the child's inability to speak?

5- What were the characteristics of that child?

6- Did that student disrupt or have an affect on your ability to competently teach in the classroom?

Yes	
No	

7- If you answered yes to question 6, please explain.

8- What was the negative role that this condition played towards you as a teacher and the child as a learner?

Teacher	
Learner	

9- In your experience of having this child in your classroom, does this condition have a positive or negative effect on the child's academic ability?

Negative	
Positive	

10- Whether you choose positive or negative, please give an explanation.

11- What was your intervention plan to help this child? Give a reason.

I was not able to help	
I was able to help	

APPENDIX 3

Student Survey

1- Do you have a friend, or know someone who does not speak in the classroom at all?

Yes	
No	

2- Does that person speak normally outside school?

Yes	
No	
I do not know	

3- How does that make you feel?

4- Why do you think this person is unable to speak in the classroom, or in school?

5- Describe this person's behavior in the classroom, or in school?

6- How do they ask the teacher for permission or for help in the classroom?

They don't, instead they stay quiet	
They use non verbal communication	
Other:	

7- Does he/she have any friends that they can talk to outside the classroom?

Yes	
No	
I do not know	

8- Since they do not speak in the classroom, do you think it has a positive or negative effect on their academics?

Positive	
Negative	

9- Based on your answer for question 8, give a reason.

10- How do you think you can help them?

APPENDIX 4

Teacher Survey Results

1- What is the condition called when a person normally capable of speech, but does not speak in specific places (school), or to specific people (teachers/peers)?

I do not know	23%
I am not sure	26%
I know the condition	51%
Total	**100%**

I know the condition	51%	Correct (Selective Mutism)	33	(33/57) x 51	29.5 ~ 30%
		Incorrect (Other)	24	(24/57) x 51	21.4 ~ 21%
		Total	**57**	**Total %**	**51%**

	#	Responses	Tally	%
I know the condition	1	Selective Mutism	33	30 %
	2	Introvert	3	21%
	3	Autism	2	
	4	Shy	8	
	5	Personality disorder	1	
	6	Inferiority complex	1	
	7	Lack of confidence	2	
	8	Afraid	1	
	9	Special needs	1	
	10	Speech phobia	1	
	11	Stage fright	1	
	12	Communication problem	1	
	13	Inability to talk	1	
	14	Child with unusual behaviors	1	
		Total	57	51%

2- In your years of experience as a teacher, did you have a student that found it difficult to communicate with you (teacher), or with peers in the classroom?

Yes	80%
No	20%
Total	100%

3- How did that make you feel as a teacher?

Responses			Tally	Total	% (TOTAL/104) x 100
Positive	**1**	**Concerned**	18	42	40.38 ~ 40%
	2	**Capable**	3		
	3	**Determined**	10		
	4	Responsible	5		
	5	**Curious**	4		
	6	**Empathy**	2		
Neutral	**7**	Challenged	14	33	31.73 ~ 32%
	8	Helpless	12		
	9	Stressed	5		
	10	Scared	2		
Negative	**11**	Frustrated	12	29	27.88 ~ 28%
	12	Uncomfortable	6		
	13	Pity	5		
	14	Anger	1		
	15	Annoyed	4		
	16	Disappointed	1		
Total			**104**		**100%**

4- What do you think is the reason behind the child's inability to speak?

#	Responses	Tally	% (X/178) x 100
1	Family dysfunction	32	17.97 ~ 18
2	Traumatic experience	4	2.24
3	Social problems	18	10.11
4	Personality insecurities	49	27.52 ~28
5	Bullying	6	3.37
6	Language problems	7	3.93
7	Immigrant family background	5	2.80
8	Autistic characteristic	2	1.12
9	Anxiety disorder	8	4.49
10	Psychological disorder	9	5.05
11	Genetic reasons	3	1.68
12	Oppositional behavior	1	0.56
13	Coping mechanism to stress	1	0.56
14	Deafness	1	0.56
15	Lack of interest	1	0.56
16	Emotional disorder	3	1.68
17	Shyness	28	15.73 ~ 16
Total		**178**	

5- What were the characteristics of that child?

#	Responses	Tally	% (X/190) x100
1	Shy	26	13.68 ~ 14
2	Quiet	21	11.05 ~ 12
3	Withdrawn	25	13.15 ~ 13
4	Anger	1	0.52 ~ 1
5	Independent	3	1.57 ~ 2
6	Misbehaving	1	0.52 ~ 1
7	Well behaved	1	0.52 ~ 1
8	Academic good standing	7	3.68 ~ 4
9	Academically weak	7	3.68 ~ 4
10	Bullied by others	1	0.52 ~ 1
11	Avoids eye contact	12	6.31 ~ 6
12	Low self esteem	2	1.05 ~ 1
13	Anxious	4	2.10 ~ 2
14	Lonely	16	8.42 ~ 8
15	Always on task	2	1.05 ~ 1
16	Calm	3	1.57 ~ 2
17	Polite	1	0.52 ~ 1
18	Negative	1	0.52 ~ 1
19	Only speaks in mother tongue	2	1.05 ~ 1
20	Thinks it’s cool	1	0.52 ~ 1
21	Uses non verbal communication	4	2.10 ~ 2
22	Speaks to selected few	1	0.52 ~ 1
23	Did not seek attention	1	0.52 ~ 1
24	Mysterious	1	0.52 ~ 1
25	Irresponsible	1	0.52 ~ 1
26	Fear	5	2.63 ~ 3
27	Lack of participation	7	3.68 ~ 4
28	Introvert	5	2.63 ~ 3
29	Visually aware	1	0.52 ~ 1
30	Lack of confidence	7	3.68 ~ 4
31	Insecure	2	1.05 ~ 1
32	Mentally not present	3	1.57 ~ 2
33	Sad facial expression	1	0.52 ~ 1
34	No facial expression	1	0.52 ~ 1
35	Stressed	1	0.52 ~ 1
36	Fidgeting	1	0.52 ~ 1
37	Crying	1	0.52 ~ 1
38	Not normal	1	0.52 ~ 1
39	Aggressive	1	0.52 ~ 1
40	Not adapted	1	0.52 ~ 1
41	Disruptive	1	0.52 ~ 1
42	Erratic behavior	1	0.52 ~ 1
43	Unresponsive	3	1.57 ~ 2
44	Slow	1	0.52 ~ 1

45	Stubborn	1	0.52 ~ 1
	Total	**190**	**99.75 ~ 100%**

6- Did that student disrupt or have an affect on your ability to competently teach in the classroom?

Yes	24%
No	76%
Total	100%

7- If you answered yes to question 6, please explain.

#	Responses	Tally	% (X/TOTAL) x 100
1	Requires more attention than others	5	20%
2	Not having any oral participation	4	16%
3	Needs separate instructions to complete work	4	16%
4	Distracts other students	2	8%
5	Answers using mother tongue	1	4%
6	Uses non verbal cues	3	12%
7	Only spoke to teacher	1	4%
8	Not active	2	8%
9	Oppositional behavior	3	12%
	Total	**25**	**100%**

8- What was the negative role that this condition played towards you as a teacher and the child as a learner?

#	Teacher	Tally	Learner	Tally
1	No teacher-student relationship	1	Difficulty in building relationships	5
2	Not helping enough	5	Difficulty in expressing needs	6
3	Irritated and disturbing	4	Lack of speaking skills	6
4	Non responsive	2	Segregated and bullied	3
5	Frustration	3	Didn't benefit from all mediums of learning	10
6	Affected class development	3	Doesn't ask questions	4
7	Disappointment	3	Not open to discover knowledge	2
8	Hampered discussion and disrupted lesson	2	Falling behind academically	18
9	Difficult to asses learning	12	Did not participate in the classroom	8
10	Alter methods of teaching	2	Is not considered a learner	3
11	Did not participate in class activities	3	Alienated and lost	2
12	Worried about distressing child	1	Language barrier	1
13	Insecure and incompetent	9	Slow learners	3
14	Time and extra work needed to help	5	Unhappy	2
15	Challenge to overcome	4	Hiding all the time	1

16	Took time from other students	6	No cooperation	3
17	Hard to build relationship with student	3	Wasting time	1
18	Can't understand students needs	2	Disadvantaged	1
19	Experience	1	Resistant to teaching	1

9- In your experience of having this child in your classroom, does this condition have a positive or negative effect on the child's academic ability?

Positive	21%
Negative	79%
Total	100%

10- Whether you choose positive or negative, please give an explanation.

	Positive		**Negative**	
1	Learning and improving	4	Ineffective communication hampers learning	11
2	Learning is not affected at all	1	Impeded their communication skills	6
3	Helped him understand the value of participation	2	Does not fully participate in classroom	14
4	Intelligent	1	Face problems progressing academically and socially	16
5	Manage with intervention treatment plans	2	Difficulty in assessing child's performance	6
6	Will help students be patient and help each other	1	Does not ask for help	7
7	Strengths outweighs weaknesses	1	No work done	6
8			Lack of support of peers	1
9			No teacher-student relationship	2
10			Not learning	1
11			Slow learner	1
12			Requires help from SEN department	1
13			Hard to deal with	1
14			Low results	5
15			Not interested in learning	5

11- What was your intervention plan to help this child? Give a reason.

I was not able to help	36%
I was able to help	64%
Total	**100%**

#	**Responses**	**Tally**	**%** **(X/103) x 100**
1	Spend time to create rapport with child	32	31.06 ~ 31%
2	Create a safe classroom environment	12	11.65
3	Curriculum modification	8	7.76
4	Show tenderness, kindness and love	3	2.91
5	Avoid Segregation	1	0.97
6	Family Therapy	9	8.73
7	Pulled out for special educational services	1	0.97
8	Speech an language therapist	9	8.73
9	Use non verbal communication	8	7.76
10	Assignment in student language	1	0.97
11	Behavioral Therapy	2	1.94
12	Play Therapy	3	2.91
13	Focus on social development	1	0.97
14	Use different learning style	5	4.85
15	Positive Reinforcement	2	1.94
16	Build Self Esteem	3	2.91
17	Extra Curricular Activities	2	1.94
18	Pair with competent student	1	0.97
Total:		**103**	99.94 ~ 100%

APPENDIX 5

Student Survey Results

1- Do you have a friend, or know someone who does not speak in the classroom at all?

Yes	88%
No	12%
Total	**100%**

2- Does that person speak normally outside school?

Yes	50%
No	7%
I do not know	43%
Total	**100%**

3- How does that make you feel?

#	Responses	Tally
1	Curious	9
2	Sad	20
3	Want to help	5
4	Worried	9
5	Bad	15
6	Privileged	1
7	Weird	5
8	Annoyed when not spoken to	1
9	Wasting time	1
10	Their opinion	1
11	Lonely	1
12	Uncomfortable being around them	1
13	Hard to talk to	2
14	Sorry for them	4
15	Happy	2
16	Normal	3
17	Bored	2
18	Quiet	1
19	Irritated	2
20	Want to befriend him/her	1
21	Feel disgusted	1
22	Glad	1
23	I do not know	1
	Total	**89**

4- Why do you think this person is unable to speak in the classroom, or in school?

#	Responses	Tally	% (X/110) x 100
1	Shy	60	54.54 ~ 55%
2	Voice problem	4	3.63
3	Sick	1	0.90
4	Doesn't understand	3	2.72
5	Afraid to get in trouble	3	2.72
6	Nervous	4	3.63
7	Afraid to say something wrong	4	3.63
8	Language incompetence	2	1.81
9	Prefers to be alone	1	0.90
10	Not listening	1	0.90
11	Sad	2	1.81
12	Angry	1	0.90
13	Gets bullied	1	0.90
14	Scared	3	2.72
15	Think they will be laughed at	3	2.72
16	Think they are hated by people	1	0.90
17	Doesn't have a friend	2	1.81
18	Has a problem	1	0.90
19	Lack of confidence	2	1.81
20	Family issues	1	0.90
21	Teacher issues	1	0.90
22	Not social	2	1.81
23	Doesn't use her mind	1	0.90
24	Nervous	1	0.90
25	Robotic	1	0.90
26	Wants the teacher to shout	1	0.90
27	Quiet personality	1	0.90
28	Isolated	1	0.90
29	Deaf	1	0.90
	Total	**110**	**100%**

5- Describe this person's behavior in the classroom, or in school?

#	Positive		Negative		Neutral	
1	Well behaved	27	Forgets homework	1	Quiet	16
2	Friendly	4	Angry	1	Occasionally speaks quietly	5
3	Polite	3	Prefers to be alone	1	Shy	6
4	Kind	5	Nervous	2	Uses non verbal communication	3
5	Good Listener	13	Awkward	1	Loves reading in the classroom	1
6	Follows the rules	1	Disobedient	6	**Irrelevant**	
7	Fine	1	Doesn't participate	2	Talks outside class	1
8	Nice	3	Scared	1		
9	Good	4	Not speaking	3		
10	Good academic standing	15	Language difficulties	2		
11	Not disruptive	2	Doesn't do anything	1		
12	Clever	9	Not moving	1		
Total		**87**		**22**		**31**
Total %		**62**		**16**		**22**

6- How do they ask the teacher for permission or for help in the classroom?

They don't, instead they stay quiet	**34%**		
They use non verbal communication	**26%**		
Other	**40%**		
Total	**100%**	**Responses**	**Tally**
	1	Occasionally Asks	7
	2	Asks in lowest voice	7
	3	Writes on paper	4
	4	Whispers in teachers ears	3
	5	Tells a friend to speak for them	8
	6	Uses sign language	5
	7	Raises their hand and waits for permission	4
	8	Writes on their computer	1
	9	Doesn't show interest in class	1

7- Does he/she have any friends that they can talk to outside the classroom?

Yes	28%
No	59%
I do not know	13%
Total	**100%**

8- Since they do not speak in the classroom, do you think it has a positive or negative effect on their academics?

Positive	23%
Negative	77%
Total	**100%**

9- Based on your answer for question 8, give a reason.

Positive	**6**	(6/31) x 100	19%
Negative	**17**	(17/31) x 100	55%
Neutral	**8**	(8/31) x 100	26%
Total responses	**31**	**Total %**	**100%**

Responses			**Tally**	**% (X/TOTAL) x 100**
Positive	**1**	Importance of communication	5	23.80 ~ 24
	2	Not disruptive	4	19.04 ~ 19
	3	Well behaved	1	4.76 ~ 5
	4	Able to listen	6	28.57 ~ 29
	5	Doesn't get in trouble	3	14.28 ~ 14
	6	Good academic standing	2	9.42 ~ 9
		Total	**21**	**100%**
Negative	**1**	Low grades	11	14.47 ~ 14
	2	Not participating	9	11.84 ~ 12
	3	No group work	2	2.63 ~ 3
	4	Can't ask for help	15	19.73 ~ 20
	5	Problem making friends	2	2.63 ~ 3
	6	Not learning	7	9.21 ~ 9
	7	Doesn't follow rules	3	3.94 ~ 4
	8	Doesn't talk	7	9.21 ~ 9
	9	Doesn't understand	5	6.47 ~ 6
	10	Will be alone	4	5.26 ~ 5
	11	Not mentally present	1	1.31 ~ 1
	12	Can't concentrate	2	2.63 ~ 3
	13	Incomplete work	2	2.63 ~ 3
	14	Very quiet	2	2.63 ~ 3

	15	Forgetful	1	1.31 ~ 1
	16	Afraid of failure	1	1.31 ~ 1
	17	Language difficulty	2	2.63 ~ 3
		Total	**76**	**100%**
Neutral	**1**	Has own reasons	1	8.33 ~ 8
	2	Shy personality	3	25
	3	Need to share feelings	1	8.33 ~ 8
	4	Talking can help	1	8.33 ~ 8
	5	Occasionally talks	1	8.33 ~ 8
	6	Needs a helper in class	1	8.33 ~ 8
	7	Focus on practicing skills	3	25
	8	I don't know	1	8.33 ~ 8
		Total	**12**	**100%**

10-How do you think you can help them?

#	Responses	Tally	% (X/116) x 100
1	Help them feel less shy	14	12.06 ~ 12
2	Be their friend	23	19.42 ~ 19
3	Try to communicate with them	24	20.48 ~ 20
4	Tell them to improve	3	2.58 ~ 3
5	Find out the problem	3	2.58 ~ 3
6	Help in participation to build confidence	7	6.03 ~ 6
7	Help them make friends	4	4.31 ~ 4
8	Help them follow rules	1	0.86 ~ 1
9	I don't know	1	0.86 ~ 1
10	Help them in studies	12	10.34 ~ 10
11	Try to make them social	4	3.44 ~ 3
12	Encourage them to speak	5	4.31 ~ 4
13	Explain why it's a negative behavior	3	2.58 ~ 3
14	Help with teacher issues	1	0.86 ~ 1
15	Helpful advice	2	1.72 ~ 2
16	Giving them confidence	1	0.86 ~ 1
17	Help them in general	5	4.31 ~ 4
18	Communication through writing	1	0.86 ~ 1
19	Chatty atmosphere	1	0.86 ~ 1
20	Spend time with them	1	0.86 ~ 1
	Total	**116**	**100%**