A case study of an electively mute child

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Abstract
Selective mutism is characterized by the appropriate use of language in certain settings, with a consistent lack of language use elsewhere. The child is often viewed as shy, and it is assumed that the shyness is temporary and will be outgrown. The purpose of this paper is to explore the problem of selective mutism in school aged children for whom silence may extend for many months or even years. Selective mutism will be further defined, and frequency, duration, and a summary of treatment methods will be discussed. A case study that illustrates positive outcomes of a behavioral approach will also be described.
A Case Study of an Electively Mute Child

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Selective mutism is characterized by the appropriate use of language in certain settings, with a consistent lack of language use elsewhere. Selectively mute children understand spoken language and have the ability to speak. In typical cases, they speak to their parents and a few selected others. Most do not speak in school and in other major social situations (Kehle, Owen, & Cressy, 1990). Selective mutes may respond, or make their needs known, by nodding their heads, pointing, or by remaining expressionless or motionless until someone correctly guesses what they want.

This disorder can negatively impact the school-aged child because it provides limited opportunity for social interaction and growth and delays the development of appropriate oral reading and word skills. The disorder also limits involvement in normal school activities, thus limiting the roles the child can play at school. Lack of participation in classes such as music, physical education, and art negatively impact the child. The child is often viewed as shy, and it is assumed that the shyness is temporary and will be outgrown. By the time selective mutism is recognized, the child has usually had at least two years in which non-verbalization has become a pattern. The behavior then becomes increasingly difficult to change because the child has found a way to avoid the anxiety of speaking. The mutism also presents limitations on the teacher and other professionals with regard to their ability to assess the child’s skills and intellectual development.

The purpose of this paper is to explore the problem of selective mutism in school aged children for whom silence may extend for many months or even years. Selective mutism will be further defined, and frequency, duration, and a
summary of treatment methods will be discussed. A case study that illustrates positive outcomes of a behavioral approach will also be described.

Definition

Selective mutism was first reported by a German physician, Kussmaul, in 1877 (as cited in Giddan, Bade, Rickenberg, & Ryley, 1995). He described physically normal children who developed mutism in certain situations. He called the condition “Asphasia Voluntals” meaning voluntary mutism. Later, in 1934, Trammer, an English physician, described several similar cases and coined the term “Elective Mutism” (as cited in Lesser-Katz, 1986). Trammer suggested that this term be used to classify children who spoke only to certain people, but not to others. The term was changed to Selective Mutism in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) (American Psychiatric Association, 1994) to imply a less oppositional or willful component. However, the majority of literature refer to “elective mutism;” therefore, the terms are used interchangeably. The Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) (American Psychiatric Association, 1994) described several communication features essential to the diagnosis of selective mutism.

A. The persistent refusal to talk in one or more social situations, including school. Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., school), despite speaking in other situations.

B. The disturbance interferes with educational or occupational achievement or with social communications.
C. The duration of the disturbance is at least one month (not limited to the first month of school).

D. The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language acquired in the social situation.

E. The disturbance is not better accounted for by a communication disorder (e.g., stuttering) and does not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder. (American Psychiatric Association, 1994, p. 115)

Onset and Frequency

The onset of the disorder is usually between three and five years of age. It is more common in children who exhibit signs of emotional conflict—excessive shyness, susceptibility to teasing, social isolation and withdrawal, clinging, difficulty in separating from their mothers to go to school, phobias, encopresis, enuresis, negativism, and temper tantrums (Shvarztman, Hornshtein, Klein, Yechezkel, Ziv, & Herman, 1990).

Persistent selective mutism is a rare childhood disorder. Morris (as cited in Wilkins, 1985) was able to find only six cases in two years, even though he had instigated a special search by the Norfolk School Health Service. Reed (1963) found a mere four cases among more than two thousand children referred to the Department of Psychiatry in the University of Manchester. Pustrom and Speers (as cited in Wilkins, 1985) found three selective mutes in one month, but no more for the next eight years. One of the largest studies to date has been done by Wright (as cited in Wilkins, 1985) who collected 24 cases in a seven year period, but he included in his sample children suffering from neurological lesions, mental deficiency and thought disorder (Wilkins, 1985). Cline and Baldwin (as cited in
Giddan, Ross, Sechler, & Becker, 1997) estimated that selective mutism occurs in less than 0.8 per 1,000 of the population. Shvarztman, Hornshtein, Klein, Yechezkel, Ziv, and Herman (1990) cited the prevalence being reported as ranging from 0.3 to 0.6 per 1,000, although among those who have attended school for only two months may be as high as 7.2 per 1,000. In 1975, Brown and Lloyd surveyed all the primary schools in Birmingham, Alabama in the United States of America to discover the prevalence of children who were not speaking at school. After eight weeks of school, 42 of 6072 children were not speaking at all (7.2 per 1,000), but after twelve months this figure had fallen to between 0.3 and 0.6 per 1,000. The DSM-IV (American Psychiatric Association, 1994) cited a rate of “less than 1%” of the clinical population as selective mutes. Based on her review of the literature, Gavilo (as cited in van der Smissen, 1995) has suggested that these statistics may be low and are not a true reflection of the occurrence rate in the population because of parental denial and non-reporting by practitioners and schools. Research showing differences in frequency between boys and girls with selective mutism is minimal.

Brown and Lloyd (1975) reported a higher incidence of selective mutism in boys than girls. However, Kolvin and Fundudis (as cited in Giddan, Ross, Sechler, & Becker, 1997), stated that selective mutism is slightly more common in females that in males. Wilkins (1985) would agree with this, as he stated that most authors have found that the condition of selective mutism is more common in girls than in boys. Rosenberg and Lindblad (1978) have reported a higher incidence of selective mutism among immigrant families and among non-first born children of large families in which one parent was described as shy.
Duration

Just as research is minimal in regard to the frequency of selective mutism between boys and girls, the same is true with duration. Giddan, Ross, Sechler, and Becker (1997) stated that selective mutism usually only lasts for only a few months, but in some cases, may persist for several years. To date, little is known about the course of the untreated selective mutism, though Hayden (as cited in Louden, 1987), in a survey of electively mute children, concluded that spontaneous remission was very rare, and when these children began speaking spontaneously, they always stopped again.

Possible Causes

The cause of selective mutism is very difficult to determine. Researchers and theorists have many different viewpoints on the possible causes of selective mutism. Possible causes that researchers have discussed are anxiety-related causes, a learned pattern of behavior, or a family systems problem.

Anxiety-Related Causes

The DSM-III-R (American Psychiatric Association, 1994) stated that elective mutism is not a symptom of social phobia, but excessive shyness is an associated feature of mutism. Most authors commented on the anxiety and profound shyness of the majority of children diagnosed as electively mute, but the relationship of elective mutism to the anxiety disorders and social phobia has been neglected in the literature (Golwyn & Weinstock, 1990). Dummit, a psychiatrist working at the New York State Psychiatric Institute, supported the concept of mutism being related to high levels of severe anxiety (as cited in Caputo & Crawford, 1993). Dummit viewed selective mutism as being caused by severe anxiety and highly recommended the medication Fluoxetine be
administered. The use of medication as a treatment will be discussed in the treatment section. Wilkins (1985) stated that, in a study conducted at the Children's Department of the Maudsley Hospital from 1968 to 1980, 24 children with selective mutism were compared to “normal” speaking children. The authors found that more mute children than controls were thought to be “anxious” and/or “depressed.” This might lead one to presume that mutism is a manifestation of an underlying anxiety state or a depressive equivalent. Louden (1987) listed many possible causes to the disorder. Selective mutism may develop as a result of anxiety resulting from emotional trauma, separation from parents, hospitalization, war, occupational mobility, or in situations where there is parental conflict, especially in families in which silence is used between the parents to express hostility and control (Kolvin & Fundudis, 198; Leonard & Topel, 1993).

**Learned Pattern of Behavior**

Reed (1963) was the first author to propose that elective mutism might be a learned pattern of behavior. He suggested that most electively mute children could be described as one of two types. One type was characterized as immature and manipulative. He proposed that elective mutism in these children was maintained by social reinforcement, (e.g., attention from parents and teachers). The second type of electively mute child was described as tense and anxious. Elective mutism in these children was suspected to be a form of speech phobia, (i.e., mutism was maintained by the avoidance of anxiety produced by speaking).

**Family Systems Problems**

Other views on causality focus on family relationships. Misch (as cited in Lesser-Katz, 1986) saw elective mutism as the child's weapon in punishing the
mother. Browne (as cited in Wilkins, 1985) would agree with Misch’s thinking on this topic. Browne described elective mutism as “a weapon to punish people who have offended” (as cited in Lesser-Katz, 1986, p.461) and noted that parental rows or violence may be causal factor in elective mutism. However, further research into the association between mutism and family hostility is needed to clarify the causal relationship, if any, that exists between them.

Misch (as cited in Lesser-Katz, 1986) noted that the secondary gains are also important. By creating an atmosphere of anxiety and worry in the family, the mute child achieves a position of power. To get his or her cooperation, the family will cater to the child’s needs and wishes. Through a family systems approach, one may also see the selective mute child as the identified “problem” of the family. In this approach, the child would play the role of the problem, keeping the focus off of the family’s “real” problem.

Many causes have been discussed, but each situation is different and the causation of selective mutism is very hard to determine. With the causation being difficult to determine, the treatment of the disorder is also problematic. There is no one clear-cut way to treat selective mutism. Golwyn and Weinstock (1990) stated there is no treatment of choice, but early intervention of some type is important.

Treatments

The mute child presents a challenge of the first order in therapy, for words are, regardless of the mode of treatment, the tools to secure a working alliance with the patient (Shreeve, 1990). Language is such a fundamental part of human relationships that the clinician cannot help but perceive the child’s silence as aggressive. However, Hayden (as cited in Shreeve, 1990) stated that only a
fraction of these children show a pattern of passive-aggressive behavior or misconduct (as cited in Shreeve, 1990). The history of treatment for selective mutism covers a broad spectrum that ranges from the psychoanalytic school of Europe in the 1800s to contemporary behavioral interventions (Labbe & Williamson, 1984). Many other treatments have been tried with varying degrees of success. Treatments that have been tried include: (a) removal of the child from the home; (b) psychoanalytic and family therapy; (c) medications; and (d) behavioral therapy, including self-modeling.

Removal of Child From Home

One of the treatments was to remove the client from his or her home in order to receive treatment. In early German psychological literature, selectively mute children were removed from the home and placed in residential treatment centers (Lesser-Katz, 1986). In a study in Norway, Wergeland (1979) described selectively mute children who were removed from their homes for periods ranging from eight months to three years. Wergeland found that untreated children were better at follow-up than children who had been removed from their homes, although no differentiation was made with regard to the severity of psychological functioning of those children who were removed (Giddan et al., 1997). According to this literature, removing clients from the home had little effect. Other therapists used a psychoanalytic and/or a family systems approach.

Psychoanalytic and Family Therapy

Chethik (as cited in Giddan et al., 1997) noted that psychoanalysis was used with some children in the past. The premise in this theory is that children who are orally or anally fixated wish to punish their parents. They may be maintaining a family secret, displacing hostility toward the mother, or regressing
to a pre-verbal stage of development. According to Krohn, Weckstein, and Wright (as cited in Giddan et al., 1997), using a psychodynamic approach is long and difficult, with a poor outcome. Family therapists had similar thoughts to psychoanalytic therapists in regard to the mother and selectively mute child relationship.

Atosnaten (1986) treated selectively mute children with psychotherapy, while all their mothers were involved in individual psychotherapy at the same time. He viewed the mutism as a vehicle for the mother's unexpressed hostility. Through it, he believed the child achieves an exclusive relationship with the mother.

Lesser-Katz (1986) found that family therapy has been suggested by some therapists both because of the presumed family pathology and the extreme secrecy noted in these families. In the case of family pathology, a family systems therapist would believe that one cannot treat the individual without treating the family unit. If the mutism is displaced hostility toward the mother, then it seems logical that a family systems approach may lead to some degree of success in getting the selective mute to speak. However, there is little evidence that a family systems approach is an effective treatment for selective mutism. Other researchers were using medication or behavioral therapy as an approach to treating selective mutism.

Medication

In a successful case of selective mutism in an elementary boy, the intervention of the medication Fluoxetine was used to relieve anxiety (Caputo & Crawford, 1993). Also used was a six-step behavioral therapy plan and parental involvement.
Golwyn and Weinstock (1990) reported possibly the first use of medication in a selective mute case. Their case involved a seven-year-old girl named Mary. Mary had a two year history of mutism outside her family. She spoke to her parents and sister without difficulty, but was mute at school and social functions. The medication phenelzine was started and gradually increased to 60 milligrams per day for 15 weeks. At six weeks, while receiving 37.5 milligrams per day, Mary began to talk more freely to her parents outside the home. At 12 weeks, at a dose of 52.5 milligrams per day, she began conversing at day-care. At 16 weeks, when school reopened, Mary spoke freely to teachers, children, and both authors. The phenelzine dose was tapered and withdrawn by Week 24. Five months later the mutism still had not recurred, and Mary never explained her silence. The use of the medication with no other specific intervention was successful in this particular case. Since many people are not open to the idea of medicating children, other treatments must be considered. Paniagua and Saeed (1988) believed that the first treatment attempt for elective mutism should emphasize the child’s verbal interactions with other people. This led to a look at a behavioral approach.

**Behavioral Approach**

Leonard and Topol (as cited in Giddan et al., 1997) stated that behavioral therapists view selective mutism as the product of a long series of negatively reinforced learning patterns. Shaw (as cited in Louden, 1987) reported a case of a 12-year-old girl who was a selective mute. The treatment used was a form of behavioral therapy in which an aversive-stimulus was used. The girl was given a series of incentives that encouraged her to speak. Failure to meet these daily requirements resulted in punishment by injections. The daily threat of an
injection became sufficiently aversive, and she began to seek relief by speaking. Because of its' extreme measures, this type of therapy would be impossible to do in a school setting.

Behavioral approaches that reduce anxiety about talking and/or reinforce the child for speaking have met with some success. Louden (1987) stated that the best treatment for chronic cases may be behavior therapy, though evidence is sketchy. Since this theory stated that selective mutism is a learned behavior, behavior modification is a preferred treatment. The approaches used with a behavioral approach are broadly those of systematic desensitization. Therapists must use a carefully laid out treatment plan in which the client is slowly desensitized to the anxiety of speaking in certain social settings. The gains using this method may be minimal in some cases. Kehle et al. (1990) stated that studies that do report successful treatment using this method typically require highly trained staff, a clinical setting, and a relatively great amount of financial and time investment.

The traditional behavioral approaches often report difficulty with the generalization of improved speaking behaviors to different social situations or settings. For example, Brown and Doll (1988) used a whole-class reinforcement program to induce peer-directed speech in a six-year-old elective mute. Subsequent to this intervention, they employed a combination of a talk-light and reinforcement to increase the frequency of the child's audible speech. Although the frequency of soft speech increased outside of the experimental situation, generalization of audible speech was not apparent.
Self-Modeling

The analysis of learning through witnessing a model was an important contribution of Bandura’s social learning theory (Bandura, 1986). To effect meaningful change in children’s behavior, modeling techniques usually require only six to eight sessions on average (Gelfand, Jenson, & Drew, 1982). These techniques are also relatively inexpensive to administer and non-intrusive. In an educational setting, this method would be called self-modeling. Dowrick and Dove (as cited in Kehle et al., 1990) defined self-modeling as the “behavior change that results from repeated observations of oneself on videotapes that show only desired behaviors” (p. 115). Bandura believed that behavior change is mediated by self efficacy. Self-modeling alters efficacy beliefs, which in turn change performance. If this line of reasoning is valid, then selective mute children, who view edited videotapes of themselves speaking in a classroom situation, may learn to believe that they can successfully communicate with their peers and teachers. According to Kehle et al. (1990), there are few studies using self-modeling as an intervention in ongoing educational settings. Those that have been conducted indicate that it is an effective treatment for a variety of dysfunctional social and interpersonal behaviors (Dowrick & Hood, as cited in Kahle et al., 1990; Piggott & Gonzales, 1987).

Piggott and Gonzales (1987) used self-modeling to treat a third-grade elective mute male in a regular educational setting. The child was academically above average and had evidenced periods of elective mutism for over four years; however he would respond to questions if his mother and/or brother were present in the classroom. Piggott and Gonzales (1987) produced classroom videotapes of him while his mother and younger brother were present. The edited self-
modeling intervention tape depicted the child responding to teacher questions and raising his hand to volunteer to answer various questions. The edited videotapes were then viewed by the child, while in his own home setting, over a period of two weeks. After this time both behaviors, answering questions and volunteering to answer questions, increased substantially. These results were maintained over the academic year.

Dowrick and Hood (as cited in Kehle et al., 1990) used a more complex design. The target children, a boy and a girl, were filmed talking in their home environments. The researchers inserted scenes of everyday classroom activities, such that the edited film depicted the children freely talking in the classroom setting. These edited films were shown to the children. The results indicated that within eight sessions of watching their respective edited films, the children’s classroom verbal interactions, although modest, were of sufficient frequency to permit normal instruction to occur. After six months, follow-up observations showed maintenance of initial gains. In the discussion of their results, Dowrick and Hood (as cited in Kehle et al., 1990) cited Bandura’s notion of insufficient perceived “self-efficacy” as an explanation for why electively mute children are responsive to self-modeling but not to peer modeling.

In the following case study, the school counselor used ideas based on Bandura’s social learning theory, self-efficacy, self-modeling, and a contingency plan to help an elementary girl with selective mutism.

Case Study

The following case study describes an intervention with a sixth grade elementary girl suffering from selective mutism. Her identity and school name have been changed to protect her privacy.
History

Jill is twelve years old and a selective mute. Since entering East Elementary part way through her third grade year, Jill had not spoken either in the school building or on the school grounds. Before coming to East Elementary third grade, Jill had attended seven different schools due to family mobility. Before this intervention, Jill would not only refuse to speak, she did not open her mouth to drink or eat lunch. She also did not use the restrooms at school. Jill spoke freely at home with her family and with family friends. Jill would speak on the school bus on the way to and from school. She was even outspoken to a degree. The moment she reached school grounds, Jill would become silent. She seldom made eye contact and frequently kept her head down. When Jill was about to smile, she quickly covered her mouth with her hand and turned her head. There were no dental problems, as her teeth were almost perfect. The other children in school supported Jill’s decision not to speak by talking for her and by telling visitors and new teachers, “Jill does not talk.” Jill was quiet, shy, rigid, and controlled. She did not raise her hand in class or participate in music, art, or physical education. When called upon, Jill did not respond and wait time, no matter how long, had no effect. Jill sometimes would refuse to do non-verbal assignments. Jill was doing quite well in school and showed indications of enjoying school and being there. Her attendance at school was very good. She had friends from her neighborhood, but did not talk to or play with them at school. At recess, she simply stood by the wall day after day, not talking to or playing with anyone. Teachers, counselors, and administrators became frustrated with Jill’s refusal to speak.
Jill's issues were brought to the school's problem solving team for suggestions. Everyone on the team was baffled by Jill's refusal to speak and could not believe the self-control she possessed. The team brainstormed interventions to try with Jill. The following options were discussed by the team members: home visits, positive reinforcement, punishment, journaling, school and mental health counseling, referral to the school district's special services, group activities, peer support, audio taping assignments at home, bribery, extinction, and withholding of privileges. Counseling and peer support had no effect on Jill speaking in school. Jill would not participate in group activities. Assignments which required Jill to participate or to give speeches began to affect her grades, so while Jill was in the end of her third grade year the team turned quickly to the parents for help.

The parents were as confused as the team because at home Jill acted just like any other child in terms of speaking. The team suggested that Jill be allowed to audio tape her speeches at home and have just the teacher listen to the tapes so that a grade could be earned. It was also agreed that Jill could call the teacher at home if she had questions about school work. For the remainder of the year and part of fourth grade, this intervention helped with Jill's academic concerns. She taped the speech assignments at home for the teacher to listen to and called the teacher on the phone and asked questions about homework. However, Jill was still not speaking at school.

The team members once again went to work by researching and reading about the behaviors Jill was exhibiting. It did not take long to find that Jill was a selective mute. The team members also found that the disorder was very rare and little is known about the cause and treatment. The team agreed with
research by Shvarztman, Hornshstein, Klein, Yechezkel, Ziv, and Herman (1990) which stated that teachers and professionals responsible for treating children with selective mutism often feel rejected, frustrated, angry, and insulted by the persistent silence with which they are faced, even when the child is functioning well at school.

**Family History**

Jill is the first born of four children. She has a sister in fifth grade, only one grade behind her. She also has twin sisters in third grade. She lives with her biological mother and father. Her paternal grandparents live nearby, and the whereabouts of her maternal grandparents are unknown. Her father travels a great deal due to his occupation. He may be gone from home for weeks at a time. This situation leaves the mother to care for the home and the four girls.

**Interventions**

After many failed attempts at getting Jill to speak in the school setting, when Jill was in sixth grade the team members decided to use some of the ideas they discovered in their research. After much consultation with one another and her parents, the team members decided to use the ideas of Bandura’s self-efficacy and a contingency management plan. The parents were willing to try this approach, but definitely did not want medication in the treatment. The team decided that the videotaping of Jill would take place at school with the help of the parents. The contingency plan would be developed by the team with input from Jill and the parents.

The basic plan of the videotaping was to videotape Jill speaking in the school setting in a controlled environment and then have Jill view the tapes, thus self-modeling speech in school. Jill would watch a tape that was made for three
consecutive days before a new tape was made. The team hoped to get Jill to agree to allow more and more people to view the tapes with her as she gained confidence in her ability to speak in a school setting. Since Jill had not spoken in a school setting for several years, the team was unsure how difficult it would be to get Jill to speak even a little.

The decision was reached that the videotaping start out very simple with low expectations in hopes of getting at least a few words. When and if this was accomplished, the expectations for Jill speaking would become greater and greater.

The team also devised a contingency plan in case Jill did not speak at all. The team members asked the mother to write, with help from Jill, a list of things that Jill would enjoy as rewards and items that she would like less as a stimulus for speaking. Jill did not know what these things were for at the time. The rewards would become more pleasant as Jill spoke more often. However if Jill did not speak, the consequences would become more unpleasant as time passed. The following is the list of rewards and consequences, from least to greatest, developed by Jill and her mother:

**Rewards:**

1. Skip one of her nights of doing dishes.
2. Cooking breakfast for everyone at her house on a Saturday morning.
3. Staying up until 10:00 instead of 8:30 on school nights.
4. No chores for one week.
5. Her cat can stay in the house for three days.
6. Purchase a mini-stereo for her room.
Consequences:

1. Bring extra wood up from the basement.
2. Doing dishes two nights in a row.
3. Going to bed 30 minutes earlier than usual on school nights.
4. Extra chores for one week.
5. No phone for one week.
6. No company may stay over night, nor can Jill stay at someone else's house.

With the contingency plan in place, the team was ready to intervene. With her parents present, the team members explained to Jill what was going to occur with the videotaping and the contingency plan. The team explained to Jill how they hoped that she would speak, as it would help her academically and socially now and in the future.

The first day of videotaping was to be with Jill and her mother alone in a classroom at school. The mother was to read ten basic, closed-ended questions to Jill and have her verbally respond. If Jill did not speak, she would receive the first designated consequence, and the team would try the same approach the next day. This would be repeated each day, with consequences getting more unpleasant, until Jill spoke. When and if this was accomplished, Jill’s teacher was to do the same as her mother. Lastly, Jill was to answer the same questions with a different adult of her choice. To the team’s amazement, Jill spoke at each of the designated times. After years of silence, she finally spoke, and the team caught it on tape. Jill received the first reward of no doing dishes at home for two days. For the next three days, Jill viewed the videotape of herself speaking to her mother, her teacher, and another staff member in the classroom with her teacher.
and school counselor. Jill was not required to speak during the viewing of these tapes, only to watch. With one successfully taping done, the team was anxious to do a second taping.

The second taping session was intended to have Jill answer more open-ended questions to encourage more talk time with her teacher. The team developed a series of ten open-ended questions about Jill. Again, Jill spoke on videotape with her teacher present. Talk time on the tape was longer than the first tape, so the team was encouraged. Jill received the next reward on the list, making breakfast for her family on a Saturday morning. For the next three days, Jill, along with her teacher and school counselor, viewed the tape of her speaking. Again, no speaking was required during the viewing.

In the third taping session, Jill read from a book with her teacher present. Talk time on tape was approximately twelve minutes. Jill received the next reward on the list, staying up until 10:00. The team suggested that students begin to watch the tapes with Jill to begin to relate her ability to speak on videotape to a regular classroom setting. Jill agreed to have three girls from her classroom view the tape along with her.

The fourth taping session was intended to have Jill again read from a book, but with one of the counselors present. During this session, Jill refused to speak the entire session. The team members were obviously disappointed, but knew there would be setbacks, so did not overanalyze the situation. Jill received the first consequence since beginning, carrying up extra wood from the basement at home.

The fifth taping session was intended to have Jill read from a new book with different adults or students who had not be videotaped with her. Jill chose to
speak with the principal and her teacher. Talk time was increased compared to passed sessions, and Jill received the next reward on the list: no chores for a week. Jill allowed all of the girls in her class to view the tape along with her for the next three days. This was especially exciting to her classmates, as most of them had never heard Jill’s voice.

The sixth taping session was intended to have Jill ask an adult ten predetermined questions and discuss the answers with them. Jill chose her teacher for the interview. Jill asked the questions, and a little discussion between her and her teacher took place after each question. Jill received the next reward, which was having her cat in the house for three days. Jill allowed the entire class to view the tape, with the exception of three boys. Again, the team members did not overanalyze why she did not want the three boys to view the tape. The self-modeling and contingency plan seemed to be working.

The intervention was now five school weeks old, and a lot of progress had been made. The team felt it was time to move past the videotaping and encourage Jill to speak in the classroom setting. Jill had viewed herself speaking in a classroom many times. Therefore, her self-efficacy in regard to being able to speak in school should have been higher than before intervention. The same contingency plan was to be used, which meant Jill needed to speak in class only once to receive the “big” reward, the mini-stereo. The team was optimistic after meeting with Jill and her teachers about the next stage of helping Jill.

Many school days passed, and there was no report of Jill speaking in class when given the opportunity. The team felt Jill was ready for this step, but apparently she did not agree. The team would need to reevaluate and decide to go back to the videotaping or take a different approach, such as the use of
medication with parental permission. This is the current situation. The team must continue efforts to help Jill with her disorder of selective mutism. Although Jill is not speaking in the classroom, the team did make great progress. Jill had not spoken in school for years and now was speaking under controlled circumstances.

Conclusion

Selective mutism is probably a symptom of both individual and family psychopathology. It should be distinguished from organic and developmental disabilities, childhood psychoses, and other emotional disorders. Mutism can be seen as a reflection of anxiety about speaking. The mutism may be a learned pattern of behavior, with the thought of speaking in certain social settings, causing anxiety levels to rise high enough to prevent an individual from speaking. Overall, learning theory has been most successful in aiding the understanding of selective mutism. Perhaps selectively mute children feel inefficacious about successful verbal interaction in the classroom setting. Selectively mute children have the verbal skills to speak in a classroom setting, but seem to lack the self-belief that they can successfully use the skills in classroom activities. This is a valid reason why self-modeling is superior to peer-modeling with selectively mute children. According to Kehle et al. (1990), the majority of studies examining the efficacy of self-modeling as an intervention to enhance children's emotional and social functioning show positive results. The intervention is relatively simple and inexpensive to use and requires little time to implement. Lastly, the procedure is well suited to fit the least restrictive components of a hierarchical educational model.
This approach seemed to have a positive effect on Jill's ability to speak in the school setting. Her anxiety about speaking in school seemed to be quite high. Through the concept of self-modeling and videotaping, Jill's anxiety appeared to be lowered as she began to speak under controlled circumstances in the school setting. A question still remains as to why Jill spoke under these controlled circumstances, but the speaking did not transfer to the classroom setting during a normal school situation. The team may not have given the videotaping enough time to truly effect Jill's self-belief that she could speak in a school setting. Perhaps with more videotaping, Jill's confidence in her ability to speak in a regular classroom setting would be great enough to lead to sustained speech. The team may need to take a different approach such as recommending family therapy, medication, or another treatment.
References


