Selective Mutism: Practice and Intervention Strategies for Children

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The onset of selective mutism (SM) is usually between the ages of three and five years, when the children first go to preschool. However, these children are most commonly referred for treatment between the ages of six and 11, when they are entering the elementary school system. Early detection and early intervention is suggested for effective SM treatment and to prevent long-lasting complications, such as socialization and learning problems. This article presents a brief literature review of SM; intervention approaches that have been used; and one SM case study that includes intervention strategies, experiences, and lessons learned from working with a child with SM. The authors' goal was to provide school social workers and teachers with a better understanding of the features of children with SM to enable early detection and early intervention in preschool and early grades in elementary school.

KEY WORDS: *early childhood mental health; early intervention; Head Start; school social worker; selective mutism*

Selective mutism (SM) is a condition in which children who normally speak well stop speaking in specific social situations, usually when they start attending school, especially preschool (American Psychiatric Association [APA], 2000). Many young children with SM remain undiagnosed for several years, until they enter the elementary school system. Because speech is an important part of communication, being unable to speak may negatively affect a child's social and emotional development. It limits opportunities for social interactions, delays appropriate language skills, and restricts school activities and social involvement with other students (Giddan, Ross, Sechler, & Becker, 1997; Krysanski, 2003). Intervention as early as in preschool or the early elementary grades may be important to helping these children overcome their problems, and it could also prevent secondary problems with socialization and learning in the later school years (Stone, Kratochwill, Sladezcek, & Serlin, 2002; Wright, Miller, Cook, & Littmann, 1985). The purpose of this article is to help school social workers and teachers gain a better understanding of the features of this disorder and to provide information necessary for early detection and intervention. We present a brief review of the literature on SM, identify various approaches to intervention, follow with a case study using behavioral intervention, and present a summary of important steps to take and a list of resources.

DEFINITION AND ETIOLOGY OF SM

SM is defined in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.) (*DSM-IV-TR*) (APA, 2000) as a disorder in which a child does not speak in specific social situations in which speech is expected (for example, school, with playmates) but speaks normally in other situations. The symptoms must last for at least one month, excluding the first month of school because many children may be shy and afraid to speak in the classroom during that period. The German physician Adolph Kussmaul first reported this disorder in the late 19th century, and, in 1934, it was named "elective mutism" by Moritz Tramer, a Swiss child psychiatrist (Dow, Sonies, Scheib, Moss, & Leonard, 1995). The disorder was first included in the third edition of the *DSM* (APA, 1980), and in the fourth edition (APA, 1994), the term "elective mutism" was modified to "SM" to indicate that these children do not speak only in "select" situations.

Features associated with SM have been described in a variety of ways, including excessive shyness, fear of social embarrassment, social isolation, withdrawal, clinging behavior, compulsive

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traits, negativism, temper tantrums, controlling, and oppositional behavior (Hungerford, Edwards, & Iantosca, 2003; Krysanski, 2003). The etiology of SM is varied. Researchers have suggested that early developmental risk factors—such as maladaptive family dynamics; unresolved internal conflicts; genetics; and histories of immigration, hospitalization, or trauma—may be causes of the condition (Cohan, Chavira, & Stein, 2006; Ford, Sladeczek, Carlson, & Kratochwill, 1998; Gordon, 2001; Kristensen, 2001; Remschmidt, Poller, Herpertz-Dahlmann, Hennighausen, & Gutenbrunner, 2001; Viana, Beidel, & Rabian, 2009). The presenting symptoms of SM, especially considering the lack of interaction with people, are similar to those of autistic disorders and some other developmental disorders and delays. Therefore, diagnostic investigations for SM should focus on anxious psychopathology and cognitive function as well as other comorbidities to prevent misdiagnosis (Kristensen, 2000; Krysanski, 2003; Viana et al., 2009).

The onset of SM is usually between the ages of three and five years, occurring on entry into a school setting (Cunningham, McHolm, Boyle, & Patel, 2004; Kristensen, 2000). The duration of SM may be from a few months to several years, and researchers have found that the longer its duration, the more resistant it can be to intervention (Bergman, Piacentini, & McCracken, 2002; Kehle, Madaus, Baratta, & Bray, 1998).

The prevalence of SM in a school-based sample from a large U.S. district has been estimated as 0.71 percent (Bergman et al., 2002). Research conducted in Israel found that the SM rate among immigrants is as high as 2.2 percent (Elizur & Perednik, 2003). It has been assumed that the frequency of SM is underestimated because the problem may not be recognized as children with SM do not usually disturb others or attract people's attention (Bergman et al., 2002; Elizur & Perednik, 2003; Kumpulainen, Rasanen, Raaska, & Somppi, 1998). Because SM may be unfamiliar to many people who are working with children (Kumpulainen et al., 1998), its characteristic behaviors may be thought to be the result of shyness and may not be seen as particularly problematic. A common misconception about SM is that a child with the condition will outgrow it. This keeps SM underreported.

In addition, because most children with SM are typically not speaking in school but frequently speaking at home, some parents may be hostile and blame the school for their child's disorder (Kumpulainen et al., 1998). School personnel are sometimes hesitant to provide assistance for a child with SM behaviors because of the parental refusals of help. These conditions make intervention for children with SM complex and difficult to carry out.

APPROACHES TO INTERVENTION

Intervention approaches that have been used with SM include behavioral, psychodynamic interventions, medication, and multimodal treatments.

Behavioral approaches emphasize modification of the environment and incorporation of techniques such as contingency management, stimulus fading, systematic desensitization, positive reinforcement, audio/video self-modeling, and cognitive–behavioral interventions (Blum et al., 1998; Carlson, Kratochwill, & Johnston, 1994; Rye & Ullman, 1999; Stone et al., 2002). In the events of the case study that follows, we applied the behavioral techniques of systematic desensitization, stimulus fading, and shaping. *Systematic desensitization*, also called "graduated exposure therapy," is a process in which an individual learns to cope with and overcome fear in small steps, which then allows him or her to take greater steps to self-reliance. In SM treatment, this technique helps to mitigate or extinguish the stress and fear responses to those specific situations that are more anxiety provoking. In *stimulus fading*, also called the "sliding-in technique," the SM individuals are brought into a controlled environment with someone with whom they are comfortable and with whom they can communicate, and then more people are added, one at a time. Because the mute situation usually occurs at school and speaking behavior is usually normal at home, a parent is usually the one who functions as the safe base, and classmates and the teacher are the people who are gradually introduced to generalize the child's vocalization. *Shaping* is a process in which a child is slowly encouraged to first communicate nonverbally, then make certain sounds, then whisper, and finally speak a word or sentence. The phrase "vocalization ladder" has been used as a metaphor to represent the shaping process for working with children with SM (McHolm, Cunningham, & Vanier, 2005; Oon, 2010). Behavioral intervention has been recognized

as the most effective approach for treating SM (Cohan et al., 2006; Viana et al., 2009).

Psychodynamic approaches emphasize identification and resolution of the child with SM's intrapsychic conflicts. The intervention process usually involves activities such as art and play therapy to facilitate communication, which enables the child to express feelings nonverbally (Manassis et al., 2003; Radford, 1977; Stone et al., 2002). The focus in a family-system perspective is on changing disadvantageous family dynamics; however, this may result in the child maintaining his or her mute behavior (Oon, 2010; Tatem & Delcampo, 1995).

Medication has been used for children with SM, taking into account the severity, duration, and resistance to psychosocial intervention of the condition (Carlson, Kratochwill, & Johnston, 1999; Kaakeh & Stumpf, 2008; Lafferty & Constantino, 1998; Stone et al., 2002). However, medication should not be the only intervention used to treat SM—it should be combined with psychosocial intervention. Currently, there are no drugs approved by the U.S. Food and Drug Administration (FDA) for use in children with SM. Antidepressants—in the form of selective serotonin reuptake inhibitors (SSRIs)—are prescribed in the treatment of people with anxiety disorders, including children with SM. Fluoxetine is the drug that has been studied most often, and its efficacy as a treatment for SM has been demonstrated (Black, Uhde, & Tancer, 1992; Dummit, Klein, Tancer, Asche, & Martin, 1996; Kaakeh & Stumpf, 2008; Silveira, Jainer, & Bates, 2004). However, in 2004, the FDA issued warnings based on reports that the use of SSRIs had caused suicidal thinking in children and adolescents with major depression (Sharkey & McNicholas, 2008). These warnings have affected and caused more concerns in medication use for mental illness in the United States. When medication is introduced for SM treatment with children, it is necessary to closely monitor the type of drug chosen and the dosage and to alert parents to possible side effects and teach them how to manage adverse events (Sharkey & McNicholas, 2008).

The *multimodal approach*, applying more than one intervention, is also frequently used to treat SM. Most multimodal treatments involve forms of psychodynamic and behavioral interventions, along with occupational therapy, dance therapy, special education, family participation, or school-based intervention and medication (when necessary) (Blum et al., 1998; Brigham & Cole, 1997; Carlson et al., 1999; Cohan et al., 2006; Joseph, 1999; Moldan, 2005). Researchers have stressed the importance of efforts—like teachers, parents, and specialists—in the intervention process for children with SM, because these children need to resume their speaking behaviors across various settings (Auster, Feeney-Kettler, & Kratochwill, 2006; Cohan et al., 2006; Oon, 2010). Many researchers have suggested that combinations of approaches may be beneficial for children, depending on their varying situations (Brigham & Cole, 1997; Cohan et al., 2006; Gordon, 2001; Moldan, 2005; Russell, Raj, & John, 1998).

CASE STUDY: RENEE

This case study involves a preschool child from an inner-city, predominantly African American Head Start center in Detroit. It illustrates the features of SM and provides examples of treatment processes that adopt a multimodal approach, using behavioral intervention, play therapy, and school and family involvement. This case also illustrates that early intervention can be effective in treating SM. The therapy sessions were conducted once a week, mainly in the classroom and an adjacent reading room, with some time also spent in other parts of the school environment. The intervention team included the therapist, two supervisors, the parents, and the teachers.

Background Information and Early Findings

Renee, a four-year-old girl, had been in Head Start for two and a half months. One of Renee's teachers found that she consistently had a blank look and was not speaking at school but did at home. Because of previous experience with a student with SM, the teacher recognized these behaviors and reported Renee to the mental health specialist. Classroom observations and assessments were initiated, and concerns were discussed with the family.

Renee's mother reported that she was her youngest child, with three older siblings. Renee was raised by her parents and had no history of serious mental or physical health problems. This was her first time attending school. Her mother was shocked by the teachers' report about Renee

not talking, because she was a very talkative and happy child at home, despite appearing shy on some occasions. Renee's father thought that there was no need for any intervention and believed she would grow out of it. However, her mother insisted that if the school believed that the intervention was necessary and appropriate, she would rather have the help for Renee. When Renee's mother asked Renee why she did not talk at school, Renee answered that she did not know why but just could not talk.

The therapist's observations confirmed Renee's teachers' reports, which showed that when teachers greeted Renee or asked her questions, she looked frozen and blank. The teachers believed that she did not like people to talk to her because it made her uncomfortable. Consequently, they gradually reinforced her behavior by avoiding interactions with her.

Initial Play Therapy Sessions

The therapist's role in the classroom was somewhat like that of a teacher, not only doing hands-on activities with the children around Renee, but also focusing on observing and interacting with Renee and encouraging interactions between her and her peers. The first time the therapist came to the classroom, Renee looked frozen and did not respond to anyone. She stood silently in a fixed position for a period of several minutes, watching the other children and the therapist. Her body was as immobile as her voice was mute. However, the therapist observed that when Renee saw others laughing, she appeared to have a very small smile, but it quickly disappeared. This observation helped the therapist to know that Renee *did* pay attention to people and her environment and that she was not as frozen as she appeared.

Right after the first classroom observation, Renee and the therapist had a chance to have 15 minutes of individual play time in the reading room, which was connected to the main classroom by an open door. The therapist invited Renee to the room and offered a hand for her to hold. Without speaking, Renee raised her hand to hold the therapist's, showing acceptance, and walked with the therapist to the room. The therapist introduced herself to Renee and told her that she was a therapist and she liked to play with little children to help them do things they found difficult to do. The therapist also told Renee that they were going to engage in whatever good and safe activities Renee liked when they were together and that Renee was welcome to tell or show her what she liked or did not like in any way, at any time. Renee seemed to be very comfortable in the room. In the warm-up activity, the therapist asked if Renee wanted to draw something and offered her paper and crayons; Renee took the materials without hesitating, sat down, and started drawing. Instead of talking to Renee directly, the therapist used a rabbit puppet to talk to her. Surprisingly, Renee answered the therapist's question about what she was drawing. She raised her head, looked at the therapist—not the puppet—smiled, and answered "A circle!" in a clear and confident voice. Then she kept drawing some lines, without answering any other questions. Later, she played puppets with the therapist, without talking, but laughed with the therapist, which was quite different from how she acted in the classroom. When the session ended, Renee went back to the main classroom and resumed her blank look and unresponsive behavior. Her gait looked much heavier and slower than it had been in the reading room. Even though Renee spoke just one sentence and remained mute on returning to the classroom, it was considered very rewarding by the intervention team to have had her first spoken sentence during the first individual session.

At the beginning of each session, some warm-up activities, along with desensitization and shaping techniques, were used to prompt Renee's speaking behavior. The warm-up activities included playing puppets and games, drawing pictures, reading books, and playing musical instruments. Activities Renee liked or had spoken of—for example, activities like the puppet play during in previous sessions—were repeated to trigger her speaking. During these activities, the therapist tried to manage Renee's stress and comfort levels and also put into words what she might be thinking or trying to say so as to induce her to speak.

Activities that Renee liked and had spoken about, like reading a book or playing a game, were repeated in subsequent sessions, with the application of desensitization and shaping techniques to encourage her to speak more regarding those items. New toys, books, and games were added to extend her willingness to speak about things with which she had less experience.

In addition, activities exploring the school environment were used to expose Renee to new situations. The therapist would ask Renee first if she would like to take a walk, and Renee was allowed to hold the therapist's hand anytime she wanted to during the walk. The therapist also gently placed her hands on Renee's shoulders or offered a hand to Renee if she sensed that Renee might be not comfortable in a new situation. The therapist would talk with Renee most of the time about what the therapist saw and felt during the walks—for example, touching an object and telling Renee how she felt when touching it. The therapist also asked Renee if she would like to try to touch and feel the object. Whenever they met anyone, the therapist would offer a friendly greeting; Renee did not have to say anything, just hold the therapist's hand so as to feel more comfortable. As Renee's mother mentioned that Renee was very interested in dancing, the therapist also observed that Renee was very afraid of approaching the stage of the school. Using Renee's strong interest in dance to diminish her fear of the stage, the therapist started introducing some environment exploration activities during the sessions. At first, Renee was encouraged to just observe the therapist's way of exploring the stage—for example, watching her go up on a stage to walk, dance, and sing. Then, rather than watching the therapist, Renee would be encouraged by the therapist to get on the stage with the therapist and, later, to stand on the stage on her own to play with or touch things freely. All the situations encountered during the walks together could potentially help Renee reduce her stress level and build her confidence in the school environment. During the therapy sessions, the therapist encouraged all attempts at communication by Renee without forcing them to happen. Renee had tried using head nodding, hand shaking, facial expressions, and drawing to communicate with the therapist. The therapist's role was to build a safe bridge and help Renee to cross the bridge to explore something new or difficult, allowing her to cross back when needed.

During these weekly sessions, Renee spoke to the therapist; however, she stopped speaking when anyone else came into the reading room. Gradually, some progress was made. When other children or Renee's teachers came into the room, she did not stop speaking but still only spoke to the therapist. To help Renee get to the transition stage of talking with teachers and other children when they came to the reading room, new intervention strategies were discussed and implemented.

School Involvement and Family Participation

Both school personnel's involvement and the family's participation were important in the generalization of Renee's speaking behavior. The therapist, teacher, and family documented Renee's progress, including observations and strategies used. In addition to the progress reports, Renee's teachers and her family were encouraged to have brief talks at school drop-off and pick-up times. These conversations were held in a friendly and informative way, either in private or in the presence of Renee, depending on the information shared. In addition, Renee's mother agreed to come to her classroom as a volunteer to help Renee have a better sense of security at school. Renee's mother also took her for walks in the school building to gradually familiarize her with the people and the environment.

Increasing Frequencies of Interaction and Speaking with People at School

After Renee had said a few sentences, selected children who were friendly to her were added to the peer-group play sessions to help her make the transition to talking with other people. Renee agreed to invite Lori, a girl who was a year older and very advanced in language expression, to join Renee and the therapist as a group for the play therapy session. Gradually, Renee was able to speak with Lori. The role of the therapist gradually faded as Renee was helped to regulate her experience by speaking with a peer. In the next therapy session, Renee was encouraged to invite two friends to play in the reading room, and at the following session, more children were engaged to play and speak with Renee. During this period of time, Renee still only spoke once a week with the children playing with her in the room and in the therapist's presence.

Shortly after three group sessions, Renee's teachers reported that she spoke for the very first time in the classroom without the therapist present. The whole class was surprised and celebrated at that moment. When Renee saw her classmates' reaction, she seemed overwhelmed.

Renee's teachers reported that she returned to her blank look for the rest of the day. The next day, one the teachers saw Renee crying sadly in the afternoon, which had never happened before. The teacher asked Renee if anyone had hurt her or if she missed her mother or if there was another reason. Renee shook her head. When the teacher asked Renee if she wanted to talk, Renee cried even louder. The teacher assumed that Renee might be sad because she wanted to talk but could not do it, making her frustrated. Renee retained her blank look and did not speak for the rest of the week.

In discussion, the intervention team realized that Renee might have experienced the same emotions that many children with SM have experienced: When their speaking behavior first appears in public, children with SM inadvertently attract a great deal of attention to themselves, and their stress level increases. This may make them feel overwhelmed and dissuade them from trying to speak again. Intervention strategies to help Renee deal with the negative experience were discussed to prevent further damage to the generalization of speech. These strategies included praising Renee's accomplishments privately and avoiding celebration by a big group to prevent her from becoming overwhelmed and, thus, increasing her stress level. The therapist also planned to work with Renee to release her stress regarding this negative experience in their following sessions.

At the following play therapy session, Renee seemed to be sad and had very little desire to speak. The therapist told Renee that she understood that the experience of speaking in the classroom and her classmates' reaction might have made her feel scared. The therapist also told Renee that the teachers had promised that if she spoke again in the classroom, her classmates would not react in the same way. Renee frowned and looked sad. A great effort had to be made to have her speak to the therapist and then to the children in the group session. As Renee's speaking behavior recovered slightly during the play sessions, she agreed to invite the teacher who worked most closely with her and her family to a session. When the teacher first came in, Renee did try but was not able to speak out. The teacher's presence apparently created a barrier for her. The therapist decided to introduce systematic desensitization and stimulus fading techniques to manage the situation. It was arranged to have the teacher gradually move in closer when Renee and the therapist were reading or talking. That way, Renee would be able to manage her comfort level when speaking in the teacher's presence. The therapist signaled the teacher about when and where to sit to get closer to Renee. The therapist tried to motivate Renee to speak using a picture book and games with which she was very familiar. After Renee started reading the book aloud to the therapist with her teacher next to her, the stimulus fading technique was used, gradually transferring the therapist's role to the teacher.

RESULTS

For the next week, Renee's teachers reported that she talked with some of her classmates and occasionally answered the attendance check in the classroom, but she only talked to the teacher in the reading room when there were no other children or teachers around. Renee's mother reported that Renee did not show much change at home, although she seemed to like to talk more about school.

There were seven sessions, but intervention was terminated at the end of the semester, just as Renee's speech was gradually appearing at school. In follow-up reports, Renee's teachers noted that she started speaking a few sentences at the beginning of the new semester and that, after two months, her frequency of speech was indistinguishable from that of other children.

RECOMMENDATIONS

The following is a summary of strategies and experiences gained from working with this case:

1. Form an intervention team involving key workers, such as a therapist, a teacher, and family members.
2. Explain the features of SM and the intervention approaches available to the intervention team; build up cooperative and collaborative relationships within the team; encourage and support the team to get involved positively in the intervention process.
3. Develop a home- and school-based intervention plan with the teachers, the family, and the child (if he or she is able to participate). Ask the family to create a list of the

situations and places where the child does and does not talk. Ask the parents about the child's strengths, likes, and dislikes and about things to avoid. Integrate this information into activities to create a best-fit intervention plan.

4. Allow the child to become familiar with the therapist with minimum stress at or before the first individual session. For example, in the case study, Renee first observed the interactions between the therapist and her classmates in a natural classroom setting.
5. Arrange for the therapist to interact and talk with the child in a place where the child normally speaks, such as the child's home, to help the child initiate verbal behavior with the therapist. This may help the child to start feeling less pressure to link his or her speaking behavior with the therapist's appearance.
6. Increase the child's sense of continuity between home and school. For example, the family may record the child reading a story at home to play back at school, or they could encourage the child to talk about school at home, without pressure, if he or she is ready to.
7. Do not allow anyone, especially team or family members, to assign blame for the child's mutism as this may increase the child's stress and worsen the condition.
8. Examine environmental factors to determine possible barriers preventing the child from speaking. Try to reduce barriers and create a more comfortable atmosphere to establish better environmental conditions. For example, have a family member with whom the child is comfortable help the child explore the school environment by talking about and introducing the school environment, by participating in school activities, and by talking with teachers and children in the classroom. In addition, family members can create opportunities for verbalization in select places where the child feels less stress and then gradually extend that to other situations.
9. Never force the child to speak, but gradually encourage all attempts at communication such as head nodding, hand shaking, facial expressions, and writing or drawing. Encourage the child to try whispering as he or she becomes comfortable with these nonverbal communications. Always allow the child to choose his or her mode of communication.
10. Minimize pressure, and emphasize trust to enable the child to build confidence in his or her attempts at verbal communication and move toward resuming his or her speaking behavior in desired places.
11. Analyze and manage all the factors that contribute to changes in the child's verbal and verbal-related behavior during all processes, especially the factors contributing to his or her stress versus comfort levels. Be sensitive to what activities or materials the child is most interested in and is more willing to speak about. Clarify in what situations—such as in specific rooms or places, playing certain games, or reading particular books—the child is more willing to exhibit speaking behavior. Use these factors as the basis to create a friendlier environment to induce speaking behavior.
12. Introduce behavioral techniques appropriately to gradually generalize the child's verbal behavior: Use systematic desensitization to help the child become familiar with new intervention situations and materials; apply shaping techniques to build communicative behaviors in small steps; use stimulus fading techniques to add peers or teachers in intervention sessions.
13. Report progress in a timely manner, including information from school and home to share with all key workers. Trace the child's current progress status and adopt appropriate intervention strategies.
14. Praise or celebrate the child's accomplishments in low-key ways that he or she is able to accept. Avoid celebrations in a big group; instead, try to praise in a more private and less stressful way.

RESOURCES

The following organizations can provide information on SM:

- Selective Mutism Anxiety Research and Treatment Center: http://www.selectivemutismcenter.org/

- American Speech–Language–Hearing Association: http://www.asha.org/public/speech/disorders/selectivemutism.htm
- K12 Academics: http://www.k12academics.com/disorders-disabilities/selective-mutism
- Selective Mutism Foundation: http://www.selectivemutismfoundation.org/
- Selective Mutism and Childhood Anxiety Disorder Group: http://www.selectivemutism.org/

CONCLUSION

As is also seen in many other developmental disabilities, early detection of SM and early intervention for children in preschool and the early elementary grades is essential and effective in overcoming delays and helping affected children to lead normal lives. It is therefore crucial that school social workers be aware of the importance of early detection of and intervention for SM. This will allow school social workers to properly train school personnel and families to recognize the condition and to understand intervention strategies.

REFERENCES

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Auster, E. R., Feeney-Kettler, K. A., & Kratochwill, T. R. (2006). Conjoint behavioral consultation: Application to the school-based treatment of anxiety disorders. *Education & Treatment of Children, 29*, 243–256.

Bergman, R. L., Piacentini, J., & McCracken, J. (2002). Prevalence and description of selective mutism in a school-based sample. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*, 938–946.

Black, B., Uhde, T. W., & Tancer, M. E. (1992). Fluoxetine for the treatment of social phobia. *Journal of Clinical Psychopharmacology, 12*, 293–295.

Blum, N. J., Kell, R. S., Starr, H. L., Lender, W. L., Bradley-Klug, K. L., Osborne, M. L., & Dowrick, P. W. (1998). Case study: Audio feedforward treatment of selective mutism. *Journal of the American Academy of Child & Adolescent Psychiatry, 37*, 40–43.

Brigham, F. J., & Cole, J. E. (1997, April). *Selective mutism: Definition, issues, and treatment.* Paper presented at the 75th Annual Meeting of the Council for Exceptional Children, Salt Lake City, UT.

Carlson, J. S., Kratochwill, T. R., & Johnston, H. (1994). Prevalence and treatment of selective mutism in clinical practice: A survey of child and adolescent psychiatrists. *Journal of Child and Adolescent Psychopharmacology, 4*, 281–291.

Carlson, J. S., Kratochwill, T. R., & Johnston, H. F. (1999). Sertraline treatment of 5 children diagnosed with selective mutism: A single-case research trial. *Journal of Child and Adolescent Psychopharmacology, 9*, 293–306.

Cohan, S. L., Chavira, D. A., & Stein, M. B. (2006). Practitioner review: Psychosocial interventions for children with selective mutism: A critical evaluation of the literature from 1990–2005. *Journal of Child Psychology and Psychiatry, 47*, 1085–1097.

Cunningham, C. E., McHolm, A., Boyle, M. H., & Patel, S. (2004). Behavioral and emotional adjustment, family functioning, academic performance, and social relationships in children with selective mutism. *Journal of Child Psychology and Psychiatry, 45*, 1363–1372.

Dow, S. P., Sonies, B. C., Scheib, D., Moss, S. E., & Leonard, H. L. (1995). Practical guidelines for the assessment and treatment of selective mutism. *Journal of the American Academy of Child & Adolescent Psychiatry, 34*, 836–846.

Dummit, S. E., Klein, R. G., Tancer, N. K., Asche, B., & Martin, J. (1996). Fluoxetine treatment of children with selective mutism: An open trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*, 615–621.

Elizur, Y., & Perednik, R. (2003). Prevalence and description of selective mutism in immigrant and native families: A controlled study. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*, 1451–1459.

Ford, M. A., Sladeczek, I. E., Carlson, J., & Kratochwill, T. R. (1998). Selective mutism: Phenomenological characteristics. *School Psychology Quarterly, 13*, 192–227.

Giddan, J. J., Ross, G. J., Sechler, L. L., & Becker, B. R. (1997). Selective mutism in elementary school: Multidisciplinary interventions. *Language Speech and Hearing Services in Schools, 28*, 127–133.

Gordon, N. (2001). Mutism: Elective or selective, and acquired. *Brain & Development, 23*, 83–87.

Hungerford, S., Edwards, J., & Iantosca, A. (2003, November). *A socio-communication intervention model for selective mutism.* Paper presented at the American Speech–Language–Hearing Association Convention, Chicago.

Joseph, P. R. (1999). Selective mutism—The child who doesn't speak at school. *Pediatrics, 104*, 308–310.

Kaakeh, Y., & Stumpf, J. L. (2008). Treatment of selective mutism: Focus on selective serotonin reuptake inhibitors. *Pharmacotherapy, 28*, 214–224.

Kehle, T. J., Madaus, M. R., Baratta, V. S., & Bray, M. A. (1998). Augmented self-modeling as a treatment for children with selective mutism. *Journal of School Psychology, 36*, 247–260.

Kristensen, H. (2000). Selective mutism and comorbidity with developmental disorder/delay, anxiety disorder, and elimination disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 39*, 249–256.

Kristensen, H. (2001). Multiple informants' report of emotional and behavioural problems in a nation-wide sample of selective mute children and controls. *European Child & Adolescent Psychiatry, 10*, 135–142.

Krysanski, V. L. (2003). A brief review of selective mutism literature. *Journal of Psychology, 137*, 29–40.

Kumpulainen, K., Rasanen, E., Raaska, H., & Somppi, V. (1998). Selective mutism among second graders in elementary school. *European Child & Adolescent Psychiatry, 7*, 24–29.

Lafferty, J. E., & Constantino, J. N. (1998). Fluvoxamine in selective mutism. *Journal of the American Academy of Child & Adolescent Psychiatry, 37*, 12–13.

Manassis, K., Fung, D., Tannock, R., Sloman, L., Fiksenbaum, L., & McInnes, A. (2003). Characterizing

selective mutism: Is it more than social anxiety? *Depression and Anxiety, 18*, 153–161.
McHolm, A. E., Cunningham, C. E., & Vanier, M. K. (2005). *Helping your child with selective mutism: Practical steps to overcome a fear of speaking*. Oakland, CA: New Harbinger.
Moldan, M. B. (2005). Selective mutism and self-regulation. *Clinical Social Work Journal, 33*, 291–307.
Oon, P. P. (2010). Playing with Gladys: A case study integrating drama therapy with behavioural interventions for the treatment of selective mutism. *Clinical Child Psychology and Psychiatry, 15*, 215–230.
Radford, P. (1977). A psychoanalytically based therapy as the treatment of choice for a six-year-old elective mute. *Journal of Child Psychotherapy, 4*, 49–65.
Remschmidt, H., Poller, M., Herpertz-Dahlmann, B., Hennighausen, K., & Gutenbrunner, C. (2001). A follow-up study of 45 patients with elective mutism. *European Archives of Psychiatry and Clinical Neuroscience, 251*, 284–296.
Russell, P.S.S., Raj, S. E., & John, J. K. (1998). Multimodal intervention for selective mutism in mentally retarded children. *Journal of the American Academy of Child & Adolescent Psychiatry, 37*, 903–904.
Rye, M. S., & Ullman, D. (1999). The successful treatment of long-term selective mutism: A case study. *Journal of Behavior Therapy and Experimental Psychiatry, 30*, 313–323.
Sharkey, L., & McNicholas, F. (2008). "More than 100 years of silence," elective mutism: A review of the literature. *European Child & Adolescent Psychiatry, 17*, 255–263.
Silveira, R., Jainer, A. K., & Bates, G. (2004). Fluoxetine treatment of selective mutism in pervasive developmental disorder. *International Journal of Psychiatry in Clinical Practice, 8*, 179–180.
Stone, B. P., Kratochwill, T. R., Sladezcek, I., & Serlin, R. C. (2002). Treatment of selective mutism: A best-evidence synthesis. *School Psychology Quarterly, 17*, 168–190.
Tatem, D. W., & Delcampo, R. L. (1995). Selective mutism in children—A structural family-therapy approach to treatment. *Contemporary Family Therapy, 17*, 177–194.
Viana, A. G., Beidel, D. C., & Rabian, B. (2009). Selective mutism: A review and integration of the last 15 years. *Clinical Psychology Review, 29*, 57–67.
Wright, H. H., Miller, M. D., Cook, M. A., & Littmann, J. R. (1985). Early identification and intervention with children who refuse to speak. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*, 1069–1075.

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