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CASE STUDIES OF SELECTIVE MUTISM IN HISPANIC CHILDREN

by

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Submitted in Partial Fulfillment of the Requirements for the
Degree of Master of Arts in
the College of Health Sciences and Human Services

Department of Communication Disorders
The University of Texas-Pan American
Edinburg, Texas

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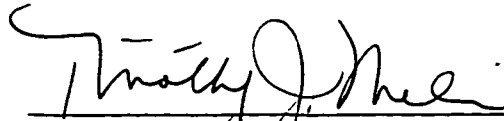
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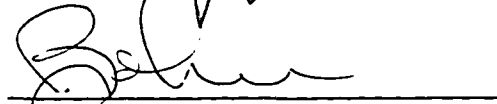
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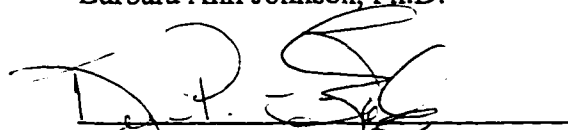
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ABSTRACT

Selective mutism is a consistent refusal to use spoken language in specific social situations. This can occur in a particular environment or with specific individuals. A collaboration of four case studies was used to study the possible etiologies, characteristics, and intervention strategies associated with selective mutism. Four children from public school campuses in the Lower Rio Grande Valley of Texas were subjects in this investigation as well as teachers and parents.

A questionnaire was used to gather data along with informal interviews. Results concluded that prevalence rates for selective mutism is relatively high in the area surveyed. Furthermore, many professional personnel are not familiar with characteristics and methods of treatment but are familiar with the term "selective mutism."

Although subjects exhibited some common characteristics they differed in personality types and did not fit the descriptions provided by the contemporary literature. It appears that subpopulations exist in the area of selectively-mute children based on etiology and characteristics presented in school and home environments.

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CHAPTER I

Introduction

This chapter introduces the reader to the problems addressed in the present investigation, discusses related factors, and describes the purpose, significance, and limitations of the study. A statement of the problem, a statement of purpose, and research questions as well as a definition for special terminology follow.

Statement of the Problem

Previous reports of selective mutism in children are mostly anecdotal and often lack a systematic approach for the collection of data. Furthermore, a standard definition for “selective mutism” was not adopted until recently. Therefore, previous studies present a heterogeneous subject pool because of differences in subject-selection criteria such as the duration of mutism prior to diagnosis. Selective mutism is a multifactorial condition and children often present with various degrees of symptoms. Not all symptoms are the same for each child nor are treatment procedures or etiologies necessarily the same. Because of a low incidence of clinical referrals for this disorder, case reports usually include only one or two children.

Additional information is needed regarding the origin, course, and resolution of the clinical entity known as “selective mutism.” This investigation intends to provide data that will contribute to a better understanding of the notion of selective mutism in children and will provide the first look at selective mutism in a sample of Hispanic children.

Purpose of the Study

The purpose of this investigation was to: (a) collect case history data from four Hispanic children with prior diagnoses of selective mutism, and (b) identify common traits and differences that may exist between subjects. In addition, the investigator looked at the relationship between early bilingual/bicultural aspects of development and selective mutism.

Research Questions

In order to address the purpose as stated above, the following specific questions were addressed: (a) What features describe the onset of selective mutism? (b) What common characteristics are shared by selectively-mute children? (c) What differences distinguish selectively-mute children? and (d) What is the affect of intervention on the course of the disorder? For example, is recovery spontaneous or are there specific contributing factors such as therapy?

Definition

Lower Rio Grande Valley of Texas. The southern most part of Texas along the border with Mexico; specifically the counties of Hidalgo, Cameron, Starr, and Willacy. This is an area with a population of 701,888 (United States Bureau of the Census, 1991) and an area of 4,837 square miles incorporating 55 population centers.

Limitations of the Study

There were factors outside the investigator's control which included the

following: (a) The design of the study limited by the number of subjects represented. The present study is not intended to be a representative sample due to the limited number of participants as well as limited time and financial resources. In addition, conclusions are limited to the investigators speculations regarding outcome data. (b) The validity of the interview method and written questionnaires is not perfect; however, the researcher believes that interviewees responded as truthfully and accurately as possible. (c) Subjects were selected from a relatively small geographic area in the state of Texas. However, conclusions can be generalized to the larger population from which the sample was drawn. Furthermore, it should be noted that subjects were selected from two school districts based on the schools' willingness to participate. (d) Not all persons asked to participate as subjects in the study cooperated fully. For example, one subject's mother elected not to be interviewed upon the researcher's arrival at the home. However, she later agreed to answer questions via telephone which were asked by the child's classroom teacher.

Significance of the Study

There is little empirical data which address prevalence, characteristics, educational needs, and the effectiveness of various interventions related to selective mutism. This investigation adds to the knowledge base for selective mutism in children especially as it regards to Hispanic-American children. Furthermore, the present study provides additional guidelines for defining selective mutism in children as well as refined

procedures for investigating selective mutism.

CHAPTER II

Review of the Literature

The following review of the literature is divided into several sections. The first section focuses on the definition and historical perspectives of selective mutism. The second section speaks to the incidence and age of onset relative to selective mutism. The final section addresses the characteristics as well as biological considerations for selective mutism.

A Definition of Selective Mutism

Historically, there have been numerous names applied to what is now widely called “selective mutism.” The disagreement about a standard definition for the disorder has caused some controversy about its classification. A useful reference for a foundation is provided by the current edition of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (4th edition-revised, DSM-IV-R, 1994). The APA classifies “selective mutism” as an anxiety disorder. Selective mutism is found beneath the subheading: “Usually first diagnosed in infancy, childhood, or adolescence.” The APA’s Diagnostic and Statistical Manual of Mental Disorders includes the following diagnostic criteria for selective mutism:

1. Consistent failure to speak in specific social situations in which there is an expectation for speaking, e. g. at school despite speaking in other situations.
2. The disturbance interferes with educational or occupational achievement or

with educational achievement or social communication.

3. The duration of the disturbance is at least one month (not limited to the first month of school).

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

5. 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. (1994, p.115)

Historical Perspective

Selective mutism was first described more than 100 years ago by the German physician Kussmal. In 1877, Kussmal coined the term “aphasia voluntaria” to describe mentally-sound individuals who were intentionally silent for reasons never disclosed. (Kratochwill, Brody, and Piersel, 1979; Krolian, 1988). Earlier literature reveals characteristics that were later identified as “elective mutism” and reported by Froeschels and Jellinek (1931) and Travis (1931). The characteristics were used as labels to describe these individuals because a diagnostic term had not yet been introduced. Heinze (1932) referred to three children he observed and labeled their behavioral characteristics as frightened, insecure, withdrawn, passive, negativistic, and too sensitive. In addition, these children reacted to new environments by becoming mute. He described this characteristic in the German literature as "Heinzian mutism" (Heinze, 1932).

A dramatic advance occurred in 1934 when Tramer coined the term "elective mutism." This term replaced all previous attempts of developing an appellation and set a standard to be followed for many years. The term "elective mutism" was used to describe children who choose not to speak in selected settings or with particular people (Tramer, 1934). This term was widely used and recognized for a number of years. During that period, there were many attempts to redefine and rename the condition. Examples of evolving names include "speech phobia" (Mora, 1962), "speech avoidance" (Lerea and Ward, 1965), "selective mutism" (Kass, Gillman, Mattis, Klugman, and Jacobson, 1967) and "reluctant speech" (Williamson, Sanders, Sewell, Haney, and White, 1977). In 1981, Kratochwill assembled a number of other terms used to describe the phenomenon including: "hearing mute," "functional mutism," "negativism," "speech avoidance," "speech inhibition," "speech phobia," "speech shyness," "suppressed speech," "thymogenic mutism," "temporary mutism," and "voluntary mutism" (Kratochwil, 1981).

Incidence of Selective Mutism

Selective mutism is considered a rare disorder. The prevalence rate is 0.3 to 0.8 per 1,000 children (Brown & Lloyd, 1975; Fundudis, Klovin, & Garside, 1979). However, Thompson (1988), Hesselman (1983), Kupietz and Schwart (1982), and Hayden (1980) concluded that incidence figures are artificially low due to underreporting the condition.

Many clinicians and others consider selective mutism to be an uncommon

disorder; however, it does not appear to be as rare as previously accepted. The dissemination of substantive information about the disorder is poor. In addition, selective mutism is not a common topic addressed in the curricula in professional training programs. Thus, many professionals have little knowledge about the identification, differentiation, and treatment of selectively-mute children. As a result, children are likely to be excluded from clinical caseloads. Therefore, they are not included in statistical surveys. Cline and Baldwin (1994) suggested additional reasons for under reporting cases of selective mutism. According to them, the most common form of reporting selective mutism in the literature is by numbers of cases served in individual clinics. These reports usually reinforce a low incidence for selective mutism. However, diagnosticians may classify selectively-mute children on the basis of different criteria. The diagnosis may be based on standard criteria but more often is based on spurious criteria (Write, 1968). Further, some treatment centers specialize with particular types of disorders. Thus, their knowledge base is likely to be focused on their specialty and limited in other respects. Therefore, the incidence of some clinical types is over reported, whereas others are under reported referrals for a specific clinical (Write, 1968). Finally, there is reason to believe that selective mutism is more prevalent in families that are socially isolated, such as immigrants who live in multi-ethnic areas of large cities or rural areas.

Many parents, teachers, and other professionals find it difficult to accept the

notion that selectively-mute children choose not to speak. Since they do not accept the basic premise for the disorder, it is unlikely that they will help in the diagnosis. Under these circumstances, a proper classification for such children is unlikely.

Many authors and clinicians have speculated that the prevalence for selective mutism is significantly higher than reported, but the lack of disseminated information about the disorder hinders its diagnosis. In addition, many of these children may go unnoticed because parents deny their children are mute in other settings because they speak normally in the home (Parker, Olsen, and Throckmorton, 1960).

Age of Onset

Early writers such as Salfield (1950) identified the most frequent age of onset for selective mutism as in the range of three to five years of age. More recent literature reveals that the typical age of onset is during the preschool years, but the average age for intervention is between six and eight years of age (Krohn, Weckstein, and Wright, 1992; Wright, Miller, Cook, and Littmann, 1985). Selective mutism is also seen to emerge around the time a child enters school. Most estimates of onset are likely to be based on the child's arrival at school because this is sometimes the first opportunity for professionals to observe the child's behavior closely. However, the child's initial entry to school may also be a precipitating factor.

Types of Selective Mutism

There have been many attempts to classify selective mutism into "types." Hayden

(1980) constructed four classes from a sample of 68 electively-mute children: (a) symbiotic mutism, (b) passive-aggressive mutism, (c) reactive or traumatic mutism, and (d) speech phobic mutism. Children who are classified as “symbiotic mutes” are characterized as having a strong relationship with a caretaker who usually is the mother. They typically exhibit heightened sensitivity and inhibitions but are not characterized as withdrawn.

Another common feature of selectively-mute children is their negative and controlling behaviors. Passively-aggressive mute children use silence as a weapon. Their refusal to speak represents an expression of hostility and a defiant refusal to speak. This behavior is sometimes manifested as antisocial or violent. These children are described as strong willed, and the act of becoming mute is viewed as a controlled choice (I. e., it is a choice they are able to manage and manipulate by their own will).

The third type, and least common, form of selective mutism reported in the literature is called “speech phobic.” In this case, the child has a fear of hearing their own voice. Hayden (1980) states that “children who are speech-phobic mutes usually possess a ritualistic and obsessive-compulsive behavior.” Also, these children may be hiding a family secret and fear that they may be unable to control their speech. If they talk, they fear the revelation of the secret. Selectively-mute children who are classified as speech phobic are thought to be the most motivated for re-establishing speech.

Last, Hayden (1980) describes selectively-mute children who are characterized as

having “reactive or traumatic mutism.” He suggests that either a single or perhaps a series of traumatic events may have triggered their mutism. This event may be considered painful to the child and most likely occurs during the child's formative preschool years. Examples of such events are: a death in the family or molestation. Such children are generally noticeably withdrawn and often lack normal facial expressiveness.

Another attempt to classify selective mutism into types was originated by Kolvin and Fundis (1981). Their classification scheme is shared by many others in the field. Kolvin and Fundis argue that there are two types of children who suffer from selective mutism: Children with traumatic mutism and children with voice disorders. Traumatic mutism is characterized by a sudden onset that immediately follows a psychological or physical shock. Some writers consider this to be hysterical in nature. The second type according to Kolvin and Fundis is a voice disorder which is not of psychogenic origin but rather the result of another type of developmental disorder. They suggest that this type of selective mutism is a maturational component that may be genetically inherited or perhaps shaped by a caregiver. This type usually is unrecognized until the child begins formal schooling. Caregivers are often unaware of the problem because the child displays normal speech development in the home.

Selective mutism should not be confused with or mistaken for any form of “biological mutism.” A few examples of clinical categories primary to biological mutism

are profound deafness, serious mental handicap, infantile autism, and schizophrenia.

Characteristics of Selective Mutism

There are a number of characteristics that children with selective mutism typically exhibit. The literature suggests that these characteristics are common to selectively-mute children. However, children with selective mutism are nonpsychotic and fully capable of talking. The key component of any description is the child's ability to talk but choose to be silent. In addition, selectively-mute children usually have normal intelligence and a normal speech mechanism. They only talk to certain people or in certain situations selectively. Finally, children diagnosed as selectively mute usually do not exhibit auditory, intellectual, or physical reasons for not verbalizing.

Thompson's (1988) description of selectively-mute children is largely in agreement with the features reported above. He includes normal hearing and normal receptive language in his list of characteristics. Thompson also suggests that children who are selectively mute have normal or near normal intellect and no physical barriers which may inhibit talking such as oral-motor impairment. Thompson (1992) describes three types of communication behaviors that are helpful in diagnosing selective mutism. First, these children may have well developed or age-appropriate expressive language skills; however, they choose mutism in certain situations. Second, they may speak with a core vocabulary of about ten to fifteen words and resist efforts by others to expand it. Third, selectively-mute children may use nonverbal means such as pointing and gestures

to communicate.

In regard to origins, an organic origin is not likely because children with selective mutism typically present no abnormalities of oral-motor skills nor do they lack the ability to display a variety of facial expressions. They are capable of eating normally and using their speech articulators appropriately. In addition, they show no signs of sensory or motor deficits. The topic of “etiology” is addressed further in the next section of this paper.

The information about characteristics of selectively-mute children is incomplete. Important areas for exploration are personality and behavioral characteristics. A thorough case history and evaluation of family life are important for determining the circumstances surrounding onset. The literature also addresses related behaviors including shyness, fear, withdrawal, obsessive-compulsive traits, negativism, temper tantrums, and controlling, oppositional behaviors. An important observation is that these behaviors are noticed in selectively-mute children but are not present in every case. Selectively-mute children are usually individualistic and exhibit unique personality traits. However, many children without selective mutism exhibit the same features. It is important to examine each individual separately and focus on the specific characteristics and combinations of characteristics that that individual possesses. Until more is known about this disorder, investigators cannot assume that related features are necessarily common traits.

Etiologic Considerations

There are several theories about the etiology of selective mutism. The bases for speculation regarding etiology vary considerably from one individual to the next and depend greatly upon the theoretical belief of the clinician (Halpern, Hammond, and Cohen, 1971). Although many authors lean toward a specific etiology for selective mutism, they often combine principles from different theories. A review of the literature suggests that the disorder is multibased and is best referred to as a multifactorial syndrome. The multiple causal factors presented include: (a) family conflict, (b) psychological trauma, (c) a fear-reducing mechanism, (d) learned behaviors, (e) psychogenic factors, (f) traumatic experience at the time of early speech development, (g) separation anxiety, (h) cultural based, and (i) immigration based factors. Other factors have been suggested such as genetic-inheritance, Freudian-based psychological roots, overly-dominant fathers, over attachment to mothers, gender, and punishment. Though there is no evidence to weigh one causal factor more heavily than another, the literature does suggest that the family is an important factor.

In regard to early literature on this subject, the leading causal factors were usually hereditary, medical, psychological, or social. The later literature tends to suggest psychodynamic and theoretic viewpoints as primary factors. Psychodynamic proponents feel that there are a combination of symptoms that contribute to selective-mutism. These symptoms are viewed as individual pathologies and those which sustain a “neurotic

family balance.” Another key concept of psychodynamic theory is that the origin decides the choice of the disturbance. For example, trauma plays an important role in understanding the subsequent behavior. Psychodynamic proponents believe that trauma may range in type and severity, such as a fall from some height to separation anxiety, sexual exposures, or death of a family member. Trauma is any event that causes a shock to the child.

Hesselman (1983) summed up the underlying notions for learning and behavioral/psychological theories of selective mutism. According to Hesselman, selective mutism is an acquired behavior. It is a technique that children acquire in order to reduce anxiety, fear, or to avoid an unpleasant experience. Children are characterized as feeling that mutism will provide them with additional privileges and attention.

Parents and relatives are usually regarded as strong models for the child. Their behaviors may be adopted by their children. As a result of this principle, attitudes of fathers and mothers may be contributing causes. Goll (1979) says that these children often have severely stern parents who use corporal punishment as their primary discipline at home. These parents are often viewed as quiet and sulky and are described as "mutist models" for their children. Goll (1979) believes that selective mutism is not only an individual problem but a family neurosis.

Reed (1963) described selective mutism as a learned behavior and proposed that it should be labeled "learned mutism." He lists two reasons for why this behavior may be

learned. The first is an attempt by the child to gain the attention of others and maintain it. The second is the child's use of silence to reduce their fears. Friedman and Karagan (1973) are also proponents of the learned-behavior theory.

Another important factor may have to do with "immigration." The notion is that immigrant children may be unfamiliar with or uncomfortable using the language of their new culture. This language may not be spoken in their home environment and as a result they may not feel confident speaking it outside the home (Bradley and Sloman, 1975).

Culture is also a potential causal factor. In some cultures, adults demonstrate their anger toward another individual by not speaking to them. It is not uncommon for people who have had a bad day to withhold verbal communication with those around them. Adults often use silence to express hostility toward one another. This method of expressing hostility can be adopted by the child. In some cultures, speaking in certain contexts or situations is forbidden. Thus, it is important to consider the child's ethnic background and cultural views.

Furthermore, investigators believe that the geographic region in which one lives may contribute to mutism. Mayer and Romanini (1973) say that "it does not depend on the social status of the child [alone]" because, in general, selectively-mute children live in socially isolated areas. They also suggest that these children are members of disharmonious families. Certain characteristics found in selectively-mute children come from qualities that either one or both parents possess, and these qualities are usually

found in previous generations.

Salfield (1950) theorized that selective mutism is used as a protective mechanism and this mechanism is directed toward particular individuals. Many authors combine this idea with other etiologic factors. The protective mechanism can occur for a number of reasons. Some of these have been discussed earlier and may include factors such as fear, secrets, abuse, and trauma.

Some authors also adopt the notion that having a family secret is an underlying cause for mutism. Family secrets, like many other traits, can range in severity, degree, and type. The family secrets may involve a wide variety of topics, such as criminality, mental illness, abuse, drug abuse, alcoholism, and extramarital relations. The secret may pertain to anything the child witnesses or perceives to be threatening in or around the home.

To sum up, the contemporary literature regarding selective mutism is limited in breadth and substance. There are numerous theories pertaining to selective mutism and numerous theories about its cause. The collection of behaviors which characterize selective mutism were known for many years as “elective mutism” but are now commonly referred to as “selective mutism.” Across many years, the defining characteristics of selective mutism have expanded and the data pertaining to this condition have become more concrete rather than speculative. Research interests in this area is increasing and, in the near future, more specialists are likely to become aware of

the diagnostic and treatment alternatives for selective mutism. This study proposes a systematic approach to gather data about selective mutism as observed in Hispanic-American children. The investigator believes that the current method presents an improvement over the many anecdotal reports as well as earlier case studies.

CHAPTER III

Method

Numerous methods are evidenced in the review of the literature for selectively-mute children. The method used in the present study is a refinement of earlier case-history methods. This chapter describes the method used to answer the questions posed by this investigation.

Procedures

Elementary principals were contacted prior to a preliminary visit at participating schools. During the initial contacts, the investigator explained the purpose of the study and described the observation procedures, questionnaire, and the rationale for a review of school records. The next step was to contact a legal guardian for each potential subject. These individuals were provided an explanation of the study (Appendix A) and were asked to read and sign an "informed-consent" form (see Appendixes B and C). This form was available in either Spanish or English. Contact was also initiated with the subjects' classroom teachers. Teachers were asked to schedule an appointment in order to complete a short questionnaire. In addition, information about the subjects' scheduled activities were requested in order to select an appropriate observation time and date.

Subjects

The subjects who participated in this investigation included teachers, parents, and four school-aged children who had a history of selective mutism. Subjects were selected

from public-school districts in the Lower Rio Grande Valley of Texas based on identification and willingness to participate.

Criteria for Selection

To be included in the study, a diagnosis of behaviors consistent with selective mutism by a psychiatrist, speech-language pathologist, teacher, and/or school counselor was required. Identifying information pertaining to each participant (i.e. age, gender, grade level, ethnicity) were included. Students met the following criteria: (a) previously identified as selectively mute, (b) no presence of developmental disorder, and (c) passed a hearing-sensitivity screening within the past year.

Justification for Sample Size

The investigator used a sample size of four due to the low incidence of subjects available and the lack of financial resources needed to implement this study across a larger geographical region. The cost of traveling throughout the state of Texas in regard to airline tickets, rental cars, food, lodging, would have made this investigation expensive and prohibitive.

Consent Forms

Consent forms were obtained from each parent or guardian of students in the study prior to beginning (see Appendixes A and B). These forms were approved by the University of Texas-Pan American Institutional Review Board for the protection of human subjects (See Appendix F). The Spanish translation was provided by a native

Spanish-language user with previous experience translating American-English to Spanish (Appendix C).

Instrumentation

To conduct this investigation, a coded questionnaire (Handley, 1994) was given to the primary caregiver and classroom teacher (see Appendix D). The questionnaire contained a brief cover letter (Spanish or American-English), which outlined the purpose of the study, restated the guarantee of anonymity, and offered the respondents an opportunity to receive information regarding the outcome of this research. A fluent Spanish-speaker was present during the interview in order to translate when necessary.

Setting

Data were collected and recorded through direct observation of each child in their school setting, review of student files, a standardized questionnaire, and face-to-face interviews. Appendix D provides the questionnaire format that was administered to caretakers and teachers. The observation of students was conducted in public-school classrooms in which these students regularly attended. The interviews with the teachers were also accomplished in the school. Three of the four parent interviews were conducted in the subjects homes and one was conducted via telephone.

Research Design

A case study design was used in order to examine potential differences and similarities between subjects. The case study method was utilized so that behaviors and

characteristics of individual subjects could be collected in a valid and reliable fashion.

Data were derived from face-to-face interviews with teachers and parents, and answers to questions contained on the questionnaire described above. All observations were conducted by the investigator or by research assistants with the investigator present.

CHAPTER IV

Results

The investigator collected detailed case information for each of the four subjects previously identified as children with symptoms consistent with “selective mutism.” The four subjects are identified as Antonia, Oralia, Lourdes, and Mirta for ease of discussion; however, these are not the actual names of children who participated in the study. The data were gathered from three distinct sources: interviews with school personnel, interviews with parents, and a standardized questionnaire. The case histories for individual children are presented in Appendix E. The results that follow are organized by nine areas of inquiry: onset of selective mutism, play and social behaviors, referral for professional help, communication by telephone, communication at school, communication with family, communication outside school, reactions of peers, and reactions of school personnel.

Silence Onset

Teacher reports. Antonia’s teacher gave no account for her silence. Oralia’s teacher speculated that Oralia may have had a traumatic experience that scared her. Lourdes’ teacher felt that she may have been frightened and as a result would become embarrassed if others heard her voice. It was also suggested that Lourdes has a speech impairment which underlies her mutism. Mirta’s teachers offered various ideas about the onset of mutism. One indicated that she was extremely shy and withdrawn; another

suggested abuse as a possible cause; and the third suggested a lack of self confidence.

One of Mirta's teachers reported that mutism had been observed in the school setting for at least one year.

Parental reports. The parent informant was the mother in each case. Onset for Antonia was reported as between two and three years of age, whereas onset was reported between four and five years of age for Oralia and Lourdes. No estimate of onset was provided for Mirta because her mother denied any knowledge about her daughter's mutism prior to this time. In this regard, Mirta's mother explained that her daughter used to get in trouble for talking too much but has now been informed that she does not talk at all.

Each mother expressed different ideas about possible causes for their child's mutism. Typically, early in the interview mothers were unsure of possible causes but as the interview progressed they were able to speculate possible causal factors. Antonia's mother suggested that she may have been traumatized by the many encounters with health professionals for treatment of her hearing problem which has now been maintained. She also mentioned Antonia's lack of self confidence as a possible factor. Oralia's mother felt that something traumatic may have happened to her daughter, such as someone threatening her in some way. Lourdes' mother recalled that she would not talk on the bus because of a fear that she might get "beat up." She added that both she and her husband thought that something traumatic may have happened to Lourdes at school such as some

punishment. The mother further reported that one of Lourdes' teachers in a former school was very unkind and overly harsh with Lourdes.

Mirta's mother was unsure of the cause of her daughter's mutism. She found it difficult to understand that her daughter was silent at school because Mirta regularly talked at home. However, as the interview progressed she confided that Mirta may be overly shy. No one reported that any of the children had offered a reason for not talking at school.

Play and Social Behavior

Teacher reports. Based on interviews and questionnaires, all children frequently interacted with their peers, but never verbally communicated in the classroom, during field trips, or on the playground. Teachers reported that the children did not verbally protest during physical encounters with peers. In addition, they did not verbalize when other children would take their possessions or verbally attack them. All but Mirta's teachers stated that other children usually kept an eye on the subject and helped when necessary. In Mirta's case, the teachers said her peers left her alone. Furthermore, she reported that the other children did not mock or abuse her in any way.

Parental reports. Background information revealed that all subjects played, interacted, and conversed with others in the home environment on a regular basis. Oralia's social behaviors were unique because she was the only child that demonstrated aggressive behaviors. She was not aggressive at school but her mother reported that

Oralia was aggressive with other children in the neighborhood. Oralia's mother described her daughter as moody in their home environment and is generally very cooperative although sometimes she throws temper tantrums when irritated. Antonia, Lourdes, and Mirta were all described as demonstrating normal play behaviors. All mothers reported that the children would verbally protest if confronted with a situation such as name calling, a fight, or having something taken from them. The one exception was Oralia who is reported to walk away from such situations.

Referral for Professional Help

Teacher reports. All of the subjects had been referred to a speech-language pathologist. Antonia and Lourdes were both placed in regular classrooms. Oralia was placed in a self-contained special-education classroom because of behavioral problems such as urinating in class as well as the mutism. Mirta attended a content-mastery program.

Parental reports. Oralia's mother reported that she was trying to find a doctor to evaluate her daughter. She described her daughter as a late talker with speech problems. In Antonia's case, her mother felt her daughters language development may be delayed because of her hearing impairment, but believed that her language was improving. Lourdes' mother believed her daughter's language development was normal. Mirta's mother did not respond.

Communication Outside the School

Parental reports. In the home, all subjects demonstrated similar behaviors. They would typically greet relatives and friends verbally. With the exception of Antonia, all children engaged in social activities outside the home. All subjects spoke both English and Spanish in their homes. However, Spanish was the primary language used in the home. An important feature of selective mutism is that the individual speaks in one setting but does not speak in another. This was documented for all four children who participated in the present study.

Communication with Family

Parental reports. Each participant reportedly used “normal” verbal communication at home. Antonia was described as being very energetic at home. Oralia was described as moody and Lourdes was described as cooperative and obedient. Mirta was described as being like any other child. At home, all subjects spoke openly and freely with family members except for Oralia who reportedly spoke and interacted with her father as little as possible.

Communication by Telephone

Teacher reports. Classmates and/or teachers attempted to communicate via telephone with Antonia, Oralia, and Lourdes. However, when the caller was identified as someone related, the child selected mutism. No such attempts were made with Mirta.

Parental reports. All subjects answered the telephone and used it to make calls.

They would talk with immediate family members and relatives but were mute with peers and teachers. Antonia was the only one who would not make calls on her own initiative. Mirta was the only subject who would talk with friends on the telephone.

Communication at School

Teacher reports. Teachers reported that no subjects were observed to engage in friendly conversation with peers. Although the subjects were mute at school peers often made it unnecessary for the selectively-mute children to talk because they would speak for them. No teachers observed any exchange of gestures and oral or written conversation among the children; however, other children accurately conveyed their needs. All subjects reportedly used head gestures to communicate yes and no or gestures such as pointing to identify a referent. Oralia and Mirta were limited in the number of gestures used in class. Mirta used only smiles to respond to questions and indicate requests. Antonia used gestures and pointing to convey her needs. Lourdes made use of a more sophisticated system, using a variety of gestures, writing and pointing for communication. All children with the exception of Mirta used appropriate eye contact when being addressed. Mirta used little eye contact during school hours.

Teachers were asked to describe the language development of subjects. Antonia's teacher stated she could not answer because she had not heard Antonia's spoken language. Although the other teachers had not heard the subjects talk either, they all made assumptions. Oralia's teacher suggested that she had delayed speech and a speech-

articulation disorder. Lourdes' teacher believed that her language development was normal. Mirta's teacher suggested that she demonstrated a language delay. All teachers reported that subjects chose to be mute with peers in the classroom and on the playground. Teachers reported asking the subjects' peers if they had ever heard the subjects speak outside of the classroom and all children reported that they had not.

Reactions of Peers

Teacher reports. All teachers reported that the subject's peers were helpful with subjects and often spoke on their behalf. Teachers further indicated that the selectively-mute children were not bothered by their peers. In fact, peers readily accepted their selectively-mute classmate.

Parental reports. Mothers reported that they never encountered problems with this situation because their children are not mute at home. However, not all children who select to be mute are accepted by their peers. In Lourdes' case, she is teased and ridiculed on the school bus and sometimes threatened.

Reactions of School Personnel

Teacher reports. All teachers agreed that they provided encouragement and support to these children to speak at school. Oralia and Lourdes' teachers provided counseling and considerable encouragement. In addition, Lourdes' teacher attempted to talk to the child via telephone but without success. Oralia's teacher provided family counseling and offered various suggestions and activities. She also continuously

reassured Oralia that she could talk whenever she felt comfortable.

Mirta's teachers reacted differentially to her mute behavior. One teacher was not surprised because she knew about it before Mirta entered her class. Another teacher was surprised that she elects to be mute in school because she enrolled herself in choir and is reported by her classmates to be vocal but opts to be silent in front of him. Among the professionals contacted, including those that were not primary informants for the study, the professionals recommended a variety of treatments. Some made it clear to the child that he or she was not expected to talk. These professionals did not want the child to feel pressured in any way. Others made sure that classmates, and anyone who questioned the mute behavior were aware to the fact that the child was accepted as a nonspeaking individual. Other professionals made numerous attempts to encourage the child to talk. One strategy was a threat that the child must talk before the end of the year or not be promoted to the next grade. Several professionals ignored the problem all together. They said that it was too time-consuming to deal with such behavior.

Parent reports. Based on their communications with school personnel, some parents reported they felt the school was incapable of properly treating their children who were labeled as selectively-mute. In Antonia's case, the relationship between school and home was strained. Mother felt that Antonia's teacher had not expressed an interest in her daughter's problem. Lourdes' and Oralia's mothers both felt the teachers were doing an adequate job helping their child. Mirta's mother did not comment because she was

unaware of her daughters mutism until this study was conducted stating that she had not been informed of the situation.

CHAPTER V

Discussion and Conclusion

The incidence of selective-mutism is not clear, but the literature is consistent in its description of selective mutism as a relatively rare disorder based on clinical referrals. Informal discussions with educators in the Rio Grande Valley of South Texas, suggests that selective mutism occurs frequently in this geographic area. Many public-school personnel (e.g., classroom teachers and speech-language pathologists) were informally interviewed during the search for potential subjects. They were not participants in the present study but did provide interesting anecdotal information. Classroom teachers and speech-language pathologists appear to be the primary resources for children who present with selective mutism.

There are many reports in the literature about selective mutism; however, past reports are usually anecdotal or include single cases. Much of what is written about selective mutism in texts and journal articles is based on theory alone with little or no scientific proof. In addition, reports are often limited by their method and usually lack a systematic comparison between selectively-mute children.

Despite the limited data and the low incidence for diagnosed cases of selective mutism, it is the responsibility of practitioners to become familiar with the appropriate labeling of these children and to acquire additional knowledge about the characteristics and alternative methods of treatment. Due to the limited research data pertaining to

selective mutism and the fact this condition may not be incorporated into the curricula of higher education (e.g., communication disorders, education, psychology, special education, and social work), these children are often mislabeled and/or misdiagnosed.

Conclusion

The present investigation addressed possible etiologies, characteristics, and intervention strategies associated with selective mutism. The first research question addressed the origin and characteristics for selective mutism in children: What features describe the onset of selective mutism?

The results of the questionnaire and face-to-face interviews indicated that these children usually spoke to immediate family members but rarely to members of their peer group or teachers. Parents of these children may be unaware of their child's mute behavior until it is reported by school personnel. Even then, parents often experience denial because the child spoke normally in the home. During the course of this study, many teachers and others reported that they have known one or more children who they presumed to be selectively mute. Until the relatively recent publication of DSM-IV-R, there had not been a widely accepted definition for selective mutes. Most published reports have made use of idiosyncratic criteria for the definition of selective mutism.

The second research question addressed the common characteristics that may be shared by selectively-mute children. The question asked: What common characteristics are shared by selectively mute children? The majority of the research literature targets

common characteristics that may lead to common causes for selective mutism in children. However, there appears to be many etiologic factors that may contribute to selective mutism either in isolation or more likely in combination. The common characteristics for all of these children appear to be (a) an election to maintain muteness in certain situations (most often school) and (b) a high degree of resistance to attempts to habilitate spoken communications. Beyond these two commonalities, there is little similarity in terms of etiologic factors or other factors.

The third question asked: What differences distinguish selectively-mute children? All of the present cases were strikingly different. Lourdes was a classic case as described in much of the literature. However, she was a minority of one in the present sample. Antonia had a history of hearing impairment. Oralia was identified as learning disabled and placed in a self-contained classroom. Mirta's primary diagnosis was cerebral palsy. According to the DSM-IV-R classification scheme, none of these children would be properly diagnosed as selectively mute. Nevertheless, these three children did possess the essential characteristics of selective mutism and should not be excluded on the basis of other handicapping conditions. The diagnoses of hearing impairment, learning disability, and cerebral palsy did not appear to be related to the onset or sequelae of selective mutism.

The fourth research question asked: What is the affect of intervention on the course of the disorder? Thompson (1988) stated that "it is essential, . . . for the speech-

language pathologist to cooperate in assessments of nonverbal children with professionals in audiology, psychiatry, psychology, and pediatrics (among others) to accurately determine the cause of the nonverbal functioning.” This advice appeared not to be well taken because many of the informants in the present study were naive as to characteristics and treatments for selectively-mute children. In some situations, even family members were unaware of their child’s behavior. The child’s behavior was often ignored at school due to the lack of information about the condition. In other situations, the extent and severity of the problem appeared to go unrecognized.

A team approach seems necessary to properly diagnose and treat children with selective mutism. In addition, practitioners need to develop effective treatment which are absent in today’s repertoire of clinical strategies. An additional need is improved dissemination of existing information about selectively-mute children to parents and school personnel.

Major Contributions of the Study

The major contribution of this study is the identification of diverse factors as well as associated characteristics among the four children studied. Furthermore, the sample size of the study was beneficial because data were obtained from four individuals in one particular region. This allowed the researcher to gather data from a larger and more diverse sample than is usual with the single case studies. Finally, data were collected for the first time from Hispanic-American children who have recently migrated to the United

States from Mexico.

Suggestions for Future Research

In light of the results of this study, the following recommendations are made:

1. Conduct cross-cultural research with selectively-mute children.
2. Investigate cultural aspects and lifestyles of selectively mute children.
3. Provide additional focus on the diversity and complexity of the disorder

rather than commonalities.

4. Repeat the present study for confirmation of results.

Gather additional data from interviews of classmates of selectively-mute children.

6. Gather a longitudinal data from the study of one or more selectively-mute children.
7. Gather exacting data regarding the incidence of selective mutism in children.

Summary

It became quite evident in trying to locate subjects for this study that the prevalence rate of children with selective-mute characteristics is prominent in the Rio Grande Valley of South Texas. While searching for potential participants, discussions with a variety of speech-language pathologists and classroom teachers revealed that most have had contact with at least one selectively-mute child. All the speech-language pathologists were familiar with the term “selective mutism;” however, few were familiar

with the characteristics or alternative treatments. This study revealed that many of these children were referred to the school speech-language pathologists by the classroom teacher.

Although they had common characteristics, such as being mute in school, the children differed in personality types, and none fit the exact description provided by the DSM-IV-R. Each of the children shared some common characteristics with selectively-mute children as described in the literature. For example, some authors describe these children as extremely shy and as avoiding attention. Furthermore, the children who participated in the study all had friends at school and, their mute behavior did not prevent regular interaction with these friends. Hopefully, future research endeavors will discover more efficacious means of treatment for children with selective mutism.

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APPENDIX A



SPEECH AND HEARING CENTER - CAS 125

THE UNIVERSITY OF TEXAS - PAN AMERICAN

1201 West University Drive, Edinburg, Texas 78539-2999 • (210) 381-3587

SELECTIVE MUTISM

PURPOSE: To collect case history data from children diagnosed with selective mutism. I expect to identify common traits, differences, potential influences, degree and variation of symptoms, and resolution. I expect to provide data that will contribute to a better understanding of the notion of selective mutism in children. Furthermore, I will provide the first look at selective mutism in a sample of Hispanic children.

CHILDREN: Children who exhibit selective mutism characteristics.

This would include the following

- Failure to speak in social situations such as school
- Duration of the mutism is at least one month
- The failure to speak is not due to lack of knowledge
- The disturbance is not better accounted for by a communication disorder or developmental disorder

SCHOOL CONTRIBUTIONS: I will need assistance in identifying children who are selectively mute. In addition, I will need information pertaining to the child that will assist me in identifying their primary caregiver.

EVALUATION TIME: Once these children are identified, and consent is obtained, a personal interview with the primary care giver will be conducted. An interview will also be conducted with the school teacher and/or special education instructor, speech pathologist or counselor which will take approximately 10 minutes. If permission is given from the parent, principle, and classroom teacher a 10-20 minute observation will be conducted in the child's classroom setting.

APPENDIX B

CONSENT FORM

Explanation of Procedures

I understand that my child is being asked to participate in a study which is intended to promote our understanding of children with selective mutism. Approximately four children will be participating in the study. The study will be run under the supervision of the University of Texas-Pan American Communication Disorders Department.

I understand that my child will be observed during academic activities in addition to leisure and recreation time. In addition, I understand that school records will be reviewed. I also understand that, if I choose to do so, I will be interviewed at a time that is convenient to me. I will be asked some questions regarding my experiences as a parent of a child with selective mutism, characteristics about my child, information pertaining to my child's medical history, and adaptations used to communicate with my child. I understand that the researcher may contact me for addition information. I understand that my child will not be disrupted during academic activities.

Risks and Discomforts

There will be an observation of your child during a routine daily activity in school and questions asked of you which will involve no apparent risks or discomfort to you or your child.

Confidentiality

I understand that my name and the name of my child and all information and records obtained about him/her will be kept in the strictest of confidence. I understand that the results of the study may be published for scientific/learning purposes provided that my identity and my child's identity are not revealed.

Withdrawal without Prejudice

I agree that all access to records and information and consent to participate was granted freely. My child's participation and any personal interviews are entirely voluntary and that even after the interview begins I can refuse to answer any specific questions or decide to terminate the interview at any point. I have also been informed that my and my child's participation or nonparticipation or my refusal to answer questions will have no effect on services that I, my child, or any member of my family may receive.

Costs to Subject from Participation in Research

I understand that there will be no costs to me for participation in the study.

Questions

I understand that the results of this study will be given to me if I request them. If I have any questions about the study or about my rights or my child's rights as a study participant, the undersigned, Colleen Gittins or Dr. Tim Meline, may be contacted at (210) 381-2181 or you may direct questions to the Communication Disorders Department at (210) 381-3587.

Agreement

I have received a copy of this informed consent. I understand that I am not waiving any legal rights by signing this consent form. My signature below indicates that I agree to my child's participation in the study.

Signature of Parent / Legal Guardian

Date

Signature of Witness

Date

APPENDIX C

Forma de Autorizacion

Explicacion del Proceso

Estoy conciente de que a mi hijo(a) se le ha pedido que participe en un estudio el cual intenta promover nuestro entendimiento acerca de la mudez selectiva infantil. Aproximadamente cuatro ninos participaran. El estudio se hara bajo la supervision del Departamento de Desordenes del Habla de The University of Texas-Pan American.

Entiendo que mi hijo(a) sera observado durante sus actividades academicas asi como en su tiempo libre. Ademas, yo estoy conciente de que los archivos academicos escolares seran examinados por personas correspondientes al estudio. Tambien, entiendo de que en dado caso apruebe dicha participacion, yo sere entrevistado(a) a un tiempo que me sea conveniente. Se me haran preguntas con respecto a mis experiencias como padre o madre de un nino(a) con mudez selectiva, se me haran preguntas sobre la caracteristicas de mi hijo(a), se me haran preguntas sobre el historial medico de mi hijo(a), asi como las adaptaciones que se usaron para comunicarme con el o ella. Entiendo que el investigador(a) podria comunicarse conmigo para proponerle informacion adicional. Estoy conciente que a mi hijo(a) no se le interrumpira durante sus actividades academicas.

Riesgos e Incomodidades

Las observaciones de su hijo(a) seran durante las actividades diarias escolares. Las preguntas que se le hagan no le causaran riesgos o incomodidades a usted o a su hijo(a).

Confidencialidad

Yo estoy conciente de que mi nombre, el nombre de mi hijo(a) y toda informacion y archivos que se obtengan acerca de mi hijo(a) estaran estrictamente bajo confidencialidad. Yo entiendo que los resultados del estudio podrian ser publicados con el unico objeto de proveer un estudio cientifico siempre y cuando la identidad de mi hijo(a) no sea revelada.

Rehusarse sin Danos

Yo estoy de acuerdo de que todo acceso a archivos, informaciones, y permisos fueron otorgados sin presion alguna. La participacion de mi hijo(a) y las entrevistas personales fueron plenamente hechas a un nivel voluntario. Entiendo de aunque el estudio haya empezado yo tengo la opcion de rehusarme a contestar cualquier pregunta o de terminar la entrevista inmediatamente. Tambien se me ha informado que la colaboracion, oposicion, o el hecho de rehusarse a contestar cualquier pregunta no afectara las asistencias que yo, mi hijo(a), o cualquier miembro de la familia reciva.

Costos por Colaborar

Yo entiendo que no habra costo alguno por tomar parte en esta investigacion.

Preguntas

Entiendo que los resultados de esta investigacion se me otorgaran siempre y cuando yo los solicite. Si llegara a tener preguntas sobre el estudio, sobre mis derechos o los de mi hijp(a) como participante en el estudio, o sobre el infraescrito, Colleen Gittins o el Dr. Tim Meline pueden ser localizados al (210) 318-2181 o puede dirigir sus preguntas al Departamento de Desordenes del Habla al (21) 318-3587.

Autorizacion

Se me ha dado una copia de este permiso informante. Al firmar este permiso, entiendo que no estoy dando de alta mi derechos legales. Mi firma indica la autorizacion de la participacion de mi hijo(a) en este estudio.

Firma del padre de familia o tutor

Fecha


Firma del Testigo

Fecha

APPENDIX D

1. SILENCE ONSET

The first section of the interview schedule is intended to explore the characteristics associated with the onset of the client's elective mutism. The attributions of the client and other people concerning the purpose of the mutistic response is also a target for assessment.

	
<p>1-1. How old was _____ when you first noticed his/her electively mute behavior? [Wergeland, 1979; Wright et al., 1985. Wright, 1968]</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't know</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 2-3 years</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 4-5 years</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 6-7 years</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 8-9 years</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (specify)</p>
<p>1-2. Has _____ ever said why he/she does not talk in/at _____? [Ambrosino & Alessi, 1979; Bednar, 1974; Colligan et al., 1977; Goll, 1979; Kaplan & Escoll, 1973; Wilkins, 1985; Wright, 1968]</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes (specify)</p>



- 1-3. Do you believe there has been any event that may have led to the onset of the mutism?
[Barlow et al., 1984; Kolvin & Fundudis, 1981; Wergeland, 1979; Wright et al., 1985; Wright, 1968]
- Hospitalization
- Separation/Divorce
- Death of family member
- Birth of sibling
- Accident or injury (specify)
- Other (specify)

- 1-4. Can you identify the last time he/she spoke in school?
[Brown & Doll, 1988]
- Yes
- No
- Don't know
- Other (specify)

- 1-5. If "yes" I wonder if you can tell me about the last time he/she spoke in your class?
-



1-6. Has _____ offered a reason for not talking in _____ ?
[Ambrosino & Alessi, 1979; Bednar, 1974; Colligan et al., 1977; Goll, 1979, Kaplan & Escoll, 1973; Wilkins, 1985; Wright, 1968]

No

Yes (specify)

1-7. In your opinion what purpose does the silence have for _____ ?
[Reed, 1963]

Attention-getting (explain)

Anxiety-reducing (explain)

Self-controlling (explain)


Expression of anger or disagreement (explain)

Other (specify)

Don't know

2. PLAY AND SOCIAL BEHAVIOR

The questions in this section allow the clinician to explore the child's interactions during play. The items are intended to identify the typical pattern(s) in the play and social behavior of the child. These observations, in turn, may be compared and contrasted with the behavior of the other children from the same setting.

	
2-1. Have you ever observed _____ playing with other children? [Pustrom & Speers, 1964; Wergeland, 1979]	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No
2-2. If yes, in your estimation how often does _____ play with other children during the course of a week?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Everyday <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 4-6 times per week <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> once per week <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> rarely (explain)



2-3. Does _____ speak to his/her peers during play? [Brown & Doll, 1988]

Yes
 No
 Don't know
 Other (specify)

2-4. If "no," has _____ ever told you why she/he does not talk to his peers during play?

Yes
 No

2-5. If "yes," I wonder if you can tell me about what _____ said about this?


2-6. Do you have an opinion about why _____ does not talk to other students during play at school?

No
 Yes
 Don't know
 Other (specify)

2-7. If "yes," in your opinion why does _____ not talk to the other students during play at school?

3. REFERRAL OF THE SILENCE USER

This section of the interview schedule explores the reason(s) for referring the person for professional help. Questions relate to the period of language acquisition, the psychosocial characteristics of the setting in which the person elects to be silent and the reactions of people to the person's speech refusal. Several items address the attempts by teachers and parents to elicit speech.

	
3-1. With reference to _____ voluntary mutism, has he/she ever received treatment from another professional? [Colligan et al., 1977; Pustrom & Speers, 1964; Wergeland, 1979]	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes (specify) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No
3-2. What made you refer _____ for treatment?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

<p>3-3. How would you describe _____ language development? [Goll, 1979; Parker et al., 1960; Wilkins, 1985]</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Normal</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Delayed</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Articulation problems</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stuttering</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (specify)</p>
<p>3-4. Did _____ need to be encouraged to speak when he/she first started talking?</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes (explain)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No (explain)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't know</p>
<p>3-5. Would you like to tell me where _____ elects to be silent?</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> In class</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> On the playground</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> On the way to school</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> On the way from school</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> At home</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (specify)</p>

3-6. Has _____ teachers ever expressed concern to you about his/her mutism? Yes (explain)

No (explain)

3-7. If "yes," what did the teacher say or do to get _____ to speak?
[Colligan et al., 1977;
Nolan & Pence, 1970;
Pustrom & Speers, 1964;
Ruzicka & Sackin, 1974;
Barlow et al., 1984]

Encourages him/her (explain)

Threaten him/her (explain)

Punish him/her (explain)

Use Token reinforcement (explain)

Use time-out with him/her (explain)

Predicts he/she will "outgrow" the problem (explain)

Other (specify)

3-8. What was your reaction
when you discovered that
_____ does not
speak in _____?

Surprise (explain)

Not surprised (explain)

Anger

Fear

Disappointment

Other


3-9. Have you or a family
member tried to get
_____ to speak
in _____?

Yes

No

4. FAMILY AND THE COMMUNITY

This component of the interview schedule addresses the nature and the extent of the family's communication outside the family and home. The way in which the client responds to strangers is also a target for assessment.

	
4-1. Do you have friends whom you see on a regular basis? [Meyers, 1984]	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No
4-2. Would you like to identify the people that you see on a regular basis?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Relatives <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Friends <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (specify)

4-3. Check the following statements which describe the verbal behavior of _____ in the presence of visitors to your home.

- Greets relatives
- Greets friends
- Greets strangers
- Answers questions directed to him/her by relatives
- Answers questions directed to him/her by friends
- Answers questions directed to him/her by strangers
- Initiates conversation with relatives
- Initiates conversation with friends
- Initiates conversation with strangers

4-4. What does _____ typically do when a stranger visits the home?

- Hides
- Leaves the room
- Cries
- Seeks comfort of mother
- Seeks comfort of father
- Other (specify)

4-5. Is there anyone in _____ immediate family who could be described as quiet to the point where he/she rarely speaks?
[Goll, 1979; Meyers, 1984]

- No
- Yes (specify)
- Uncertain (explain)

4-6. Does _____ take part in any activities outside the home?
[Meyers, 1984]

- Yes (specify)
- No (explain)

<p>4-7. How long has _____ lived at his/her current address?</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 10 or more years</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 6-9 years</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 4-5 years</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 2-3 years</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 1 year</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> less than a year</p>
<p>4-8. Is a language other than English spoken in _____ home? [Bednar, 1974; Calhoun & Koenig, 1973; Conrad et al., 1974]</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes (specify)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No</p>

5. COMMUNICATION OF THE SILENCE USER WITHIN THE FAMILY

Questions are directed at the form and frequency of communication within the family. The purpose is to provide an estimate of reluctant speech, self-initiated speech, low volume speech (whispering), and the frequency of normal speech acts within the family. Information is solicited either directly or through an informant to identify, if and how, the setting and the behavior of others needs to change in order for the client to talk. In addition to obtaining answers to the questions, it is desirable to obtain audio recordings of the child's verbal communication from settings in which he or she talks to permit the formulation of realistic treatment goals.

- 5-1. Does _____ talk at home? Yes
[Nolan & Pence, 1970;
Wergeland, 1979] No
 Rarely (explain)

- 5-2. How would you describe
_____ behavior at
home?
[Nolan & Pence, 1970;
Reed, 1963; Wright,
1968] Obedient/Co-operative
(describe)
 Defiant (describe)
 Withdrawn (describe)
 Passive-Aggressive
(describe)
 Other (specify)

- 5-3. To whom does _____ speak?
[Reed, 1963]
- Mother
- Father
- Sister(s)
- Brother(s)
- Non-family (specify)

- 5-4. How would you describe _____ talking at home?
- Echolalic speech
- Reluctant speech
- Self-initiated speech
- Electively mute
- Whispers
(low volume speech)

- 5-5. Does _____ verbally protest when another person calls him/her names?
- Yes
- No
- Don't know

- 5-6. Does _____ verbally protest when another person takes something which belongs to him/her?
- Yes
- No
- Don't know

5-7. Does _____ verbally protest when another person strikes him/her?

Yes

No

Don't know

Other occasions (specify)

5-8. Have you attempted to get _____ to talk in the target setting?

Yes

No

<p>5-9. If "yes," what have you done to get _____ to talk outside of the home? [Nolan & Pence, 1970; Rosenberg & Lindblad, 1978; Wergeland, 1979; Williamson et al., 1977]</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Encourage him/her (explain)</p>
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Become angry with him/her (explain)</p>
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Threaten him/her (explain)</p>
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Punish him/her (explain)</p>
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Other (specify)</p>
<p>5-10. Did _____ ever say what would have to happen for him/her to begin to speak in the target setting?</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Yes</p>
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>No</p>
<p>5-11. If "yes," what did _____ say would have to happen for him/her to talk?</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

6. TELEPHONE USE OF THE SILENCE USER

The aim of this section of the interview guide is to determine if the client will talk to someone whom he can hear but cannot see. The data has implications for selecting a telephone for play therapy, for positive self-modeling and for interventions based on gradually exposing the person to the settings in which he or she is silent.

6-1. If asked to answer the telephone with whom will he/she speak?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mother
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Father
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grandmother
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grandfather
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aunt
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uncle
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sibling
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cousin
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Close Friend
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify)

<p>6-2. Will _____ answer the telephone? [Parker et al., 1960; Rosenberg & Lindblad, 1978; Williamson et al., 1977]</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	No
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sometimes (explain)
<p>6-3. Will _____ make a telephone call on his/her own?</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	No
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rarely (specify)
<p>6-4. If "yes," who does he/she call?</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Family member (specify)
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Non-family member (specify)

7. COMMUNICATION OF THE SILENCE USER IN THE TARGET SETTING

This section of the interview focuses on the gestural communication and the speech-acts of the client in the setting in which he or she elects to be silent. In addition to obtaining answers to the questions, it is useful to record samples of the verbal behavior of several other students in a variety of learning and social activities. This permits the clinician to make comparisons between the client's pattern of communication and the communication pattern of children from the same setting.

<p>7-1. Does _____ speak to his/her peers? [Brown & Doll, 1988]</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't know</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (specify)</p>
<p>7-2. If "no," has _____ ever indicated why he/she does not talk to his/her peers?</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No</p> <p style="text-align: center;">If "yes," I wonder if you can tell me about what he/she said about this?</p> <p style="text-align: center;">If "no," why do you think he/she does not talk to his/her peers?</p>
<p>7-3. How does _____ indicate that he/she wants something when in a setting in which he/she does not speak? [Colligan et al., 1977; Parker et al., 1960]</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Whispers</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gestures</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Writes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vocalizations – not words (e.g., sounds such as coughing, throat clearing, etc.)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Helps himself /herself independent of others</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (specify)</p>

<p>7-4. Can you identify the last time _____ spoke in school? [Brown & Doll, 1988]</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Yes</p>
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>No</p>
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Don't know</p>
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Other (specify)</p>
<p>7-5. If "yes," I wonder if you can tell me about the last time he/she spoke in your class.</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<p>7-6. Does _____ respond with gestures if instructed to do so? (e.g., nod his/her head for "Yes" – move his/her head from side-to-side for "no.") [Brown & Doll, 1988]</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Yes</p>
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>No</p>
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Don't know</p>
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Other (explain)</p>
<p>7-7. If "yes," can you identify the gestures which he/she typically uses?</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<p>7-8. Does _____ exhibit eye contact when you are talking to him/her?</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Yes</p>
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>No</p>
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Don't know</p>

8. REACTIONS OF PEERS TO THE SILENCE USER

This part of the interview schedule permits the clinician to record the reactions of other people to the client's use of silence.

<p>8-1. How do other people react to _____ silence? [Bauermeister & Jemail, 1975; Pustrom & Speers, 1964; Ruzicka & Sackin, 1974]</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Helpful (explain)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unfriendly (explain)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ignore (explain)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (specify)</p>

9. INFORMAL TREATMENTS

It is important for clinicians to determine if informal remediations have been applied in the past. If they have been applied, it is important to obtain a detailed account of the informal interventions. The impressions of the informants about the informal treatments to which the client has been exposed will be useful in designing alternative treatments.

9-1. Have you tried to get _____ to talk in the target setting?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (specify)
9-2. If "yes," what have you done to get _____ to talk in the target setting? [Nolan & Pence, 1970; Rosenberg & Lindblad, 1978; Wergeland, 1979; Williamson, et al., 1977]	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Encourage him/her (specify) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Threaten him/her (specify) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Punish him/her (specify) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Become angry with him/her (specify) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (specify)

<p>9-3. What does the teacher say or do to get _____ to talk at school? [Colligan et al., 1977; Nolan & Pence, 1970; Pustrom & speers, 1964; Ruzicka & Sackin, 1974; and Kehle et al., 1990]</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Encourages him/her (specify)</p> <p>Change of classroom (specify)</p> <p>Theatens him/her (specify)</p> <p>Punishes him/her (specify)</p> <p>Becomes angry with him/her (specify)</p> <p>Other (specify)</p>

10. TREATMENT BY QUALIFIED PROFESSIONALS

This section is designed to permit the therapist to obtain information from family members about the nature and characteristics of the previous treatments and the status of the client at the conclusion of previous treatment(s). The data will assist the clinician in avoiding the pitfalls of the previous treatment(s) and in designing a treatment for the client which has a greater likelihood of being effective.

10-1. Has _____ received professional help for his/her speech-refusal?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	No
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Don't know
10-2. If "yes," tell me about the treatment. [Norman & Broman, 1970; Nolan & Pence, 1970; Brown & Doll, 1988]	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Class-based behavior management program.
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Fading
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Biofeedback (voice-lite®)
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Token Reinforcement
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Other (specify)
10-3. Did the intervention employ positive enforcement?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	No
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Don't know
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Other (specify)

<p>10-4. If "yes," what was the purpose of the reinforcement procedure? [Lachenmeyer & Gibbs, 1985]</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> To provide for incentive for the client to speak.</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> To provide feedback to increase the clients' confidence.</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> To provide external control of clients' behavior.</p>
<p>10-5. Did you play a part in the professional treatment?</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No</p>
<p>10-6. If "yes," would you like to tell me about your participation?</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

10-7. Was the professional treatment helpful to your child?

Yes (explain)

Somewhat (explain)

No (explain)

APPENDIX E

CASE HISTORIES

Antonia

Antonia is a six-year-old Hispanic-American female in the first grade of school. She lives at home where the dominant language is Spanish. Her mother reported that she was two- to three-years-of-age when they first noticed her selective mutism. Antonia has lived at her current address for about seven years, although she does not reside in the same location for the entire year. Her family lives at home for about eight months and in California for the remaining months.

Antonia does not volunteer a reason for her periodic mutism and only shrugs her shoulders in response to questions. Her mother feels that Antonia lacks self confidence so does not respond to others. Because of intermittent hearing problems, Antonia has a history of visits to physicians for treatment. Her mother speculates that these visits may have contributed to the mutism.

According to the parent's report, Antonia has never been very verbal at home. She was reportedly independent in meeting her needs. For example, Antonia often got her own food rather than asking for it. Mother reports that she talks at school but only with other children, not adults, and she speaks at home to family members. Antonia's older sister encourages her to speak with others but Antonia withdraws to her mother or father when encountering unfamiliar adults. Other family members are characterized as quiet. For example, Antonia's older sister also prefers not to speak with distant relatives that she seldom sees. Her father is also reportedly a quiet person which is described as a family trait. As a result of her reticence, Antonia does not participate in activities outside

the home. Her mother has encouraged her to participate in activities such as ballet but Antonia refuses.

Antonia is described as energetic at home. She is also characterized as “spoiled.” However, family members are attempting to encourage more social behavior. At home, Antonia answers the telephone but does not speak. Occasionally she responds with a one-word greeting and laughs. Antonia often uses gestures to communicate her needs.

Antonia does not speak at school. During her stay in California, she attends school for two or three months. On her return home, she is placed in a bilingual public school program for the remainder of the school year. Antonia’s classroom teacher at her home school had little to say about Antonia. She did make it clear that she had no opinion about the cause of Antonia’s mutism. Antonia is regularly observed playing with other children at school by family members and school personnel. However, teachers report that Antonia does not speak with others during school.

Antonia received speech services in both the school setting and a rehabilitation center for her speech problem. She was referred to a rehabilitation agency by her mother who was seeking additional help. Antonia’s language development is reported as being slightly delayed secondary to hearing loss. She reportedly babbled and spoke her first words at a developmentally appropriate age. She progressed to two-word combinations but is described as speaking in incomplete sentences during later development.

Antonia’s teachers have expressed concern regarding her mutism. Her current teacher felt that because of her silence she required more attention than the other children. Although the teacher expressed concern, her mother’s opinion is that the teacher

has not make a significant effort to get Antonia to speak in school. The teacher acknowledged her ignorance about selective mutism. She reported that this was her first encounter with a child like this and inasmuch as this was her last year of teaching she was not interested in learning about selective mutism.

At home, if someone takes something that belongs to her or someone strikes her, she verbally protests but does not respond at school. Her teacher reported that in these situations Antonia does not have to say or do anything because other children look after her. Attempts have been made by family members and teachers to encourage Antonia to talk in school. This includes encouraging her to communicate verbally and confidence building.

Antonia uses appropriate eye contact when talking to people and demonstrates eye contact during interpersonal interactions but remains mute. There are several people who have made substantial efforts to encourage Antonia's use of speech. For example, her aunt visits and tries to teach her how to pronounce her words correctly. Antonia is presently enrolled in speech-language therapy services at her school.

Lourdes

Lourdes is an eight-year-old Hispanic female who is attending the second grade of public school. She has lived with her parents, three sisters and one brother at the present address in a "Colonia" for one-and-a-half years. Spanish is the primary language spoken in the home, although Lourdes speaks both Spanish and English. She plays with other children regularly at home and school. However, Lourdes verbalizes a lot at home and in the neighborhood but not at school. At home, her mother reports that she likes to

role play. She often pretends to be a teacher and gives instructions to other children in her home. Lourdes enjoys reading books aloud to neighbors and friends and is reported to create her own plays and act them out.

At school, Lourdes does not speak with school mates. However, she does interact with others regularly and participates in scheduled activities. She is also mute when interacting with her brother at school but not at home. At home, Lourdes is friendly and converses with family members and strangers as long as they are not connected to school. No other family members are characterized as particularly quiet. Her parents do not know why she does not verbalize at school. Lourdes' overall behavior at home is described as obedient and cooperative. At home she verbally protests if someone taunts her but not at school. However, she will act out the event such as pointing at the individual and demonstrating "hair pulling."

Lourdes does talk to family members on the telephone but will not talk with friends. She avoids exchanging phone numbers with classmates. Some have telephoned her because they want to hear her voice; however, when she answers and recognizes a classmate, she refuses to talk. During the past year, she has read 120 books and has written reports for each one.

Her mother reported that she first demonstrated selective mutism at four- or five-years-of-age. Mother also reported that Lourdes implied that her mutism began following an instance of extreme embarrassment that occurred several years past. Her mother feels that a traumatic event of some kind occurred at school and led to her mute behavior. Lourdes' teacher speculates that she may have experienced an emotional

trauma because she is easily frightened by loud noises in the classroom. For example, the teacher reported that a balloon popped one day and Lourdes began to cry. The teacher has never heard Lourdes speak in class. Her mother reported that Lourdes is afraid of being abused by other children on the school bus if she talks. She stops talking as soon as she gets on the bus in the morning and only talks again when she gets off the bus in the afternoon. In addition, mother recalled that in a former school, Lourdes was enrolled in an English only classroom for two months and then placed in a bilingual classroom. Mother speculates that the English only class was possibly traumatic. Lourdes' first-grade teacher shared a number of observations. She reported that Lourdes did respond well to humor in the form of jokes. She was observed smiling and vocalizing. She was able to communicate daily needs by gestures and communicated feelings by facial expressions.

Lourdes' present teacher feels that maybe she is frightened because she is embarrassed for others to hear her talk and suggested the presence of a speech defect. However, her mother has not noticed an abnormality in her speech. Her brother is reported to have a fluency disorder, but Lourdes has not shown any evidence of disfluency. She has received help from the school speech-language pathologist as well as the school counselor. She has not received services or been referred to any professional outside of the educational system. Mother and teacher believe that her language development is normal. Academically, Lourdes is reported to be above average and an active participant in classroom activities. Lourdes' mother and teacher agree that she is consistently mute in class, on the playground, and on the way to and from school.

When asked how others respond to Lourdes' mutism her teacher reported that all the children are helpful and friendly. Lourdes helps classmates with their compositions by checking spelling grammar.

Mirta

Mirta is a thirteen-year-old Hispanic female who is also afflicted with cerebral palsy. She lives at home with both parents and an older brother and sister. She currently attends the seventh grade in a junior high school located near her home where she has lived for some time. The dominant language spoken in the school is English, although her family speaks mostly Spanish at home. Mirta is wheelchair-bound with poor upper body movement. She is involved in a content mastery program in which one teacher has primary responsibility for teaching specific content areas while the special-education teacher teaches specific skills.

Mirta's case history is incomplete because the family refused a face-to-face interview. However, information was obtained by telephone. Mirta's alternates classrooms for each subject. Thus, three teachers were interviewed. Her mother reported that Mirta is only shy in the school building not during field trips. She stated that when she takes her daughter out, she verbalizes in all settings and requests items in stores. At home, she talks to friends and cousins and speaks to others in the neighborhood. Mirta reportedly interacts with her sister's friends and calls one friend on the telephone. At home, she speaks English with her sister but Spanish with her parents. Mother reports that she is just like any other child, and she will verbally protest if a child bothers her or makes fun of her around her home.

Mirta's mother was not sure of the onset of her daughters mutism. She has heard more about her daughters silent behavior over the past year, but prior to that she was not aware of the situation. One of her teachers reported that in the cumulative record it says

she has been silent since fourth grade. Furthermore, it says that she has never offered a reason for not talking.

When the teachers were asked if they had any notion as to why Mirta refuses to talk in school, one responded that maybe she is shy; another stated that she may have experienced some type of abuse (there was no evidence to verify this assumption); and one had no idea. Her mother feels that her daughter is probably overly shy.

Mirta did volunteer for choir practice at school. Her choir teacher reports that Mirta sings, but if anyone is listening to her she would probably stop. The music instructor stated that he attempted to leave the room and then return while they were singing (the door was located in the back of the auditorium) so that he could listen to her sing without Mirta's notice. However, he has not been able to accomplish this task as yet. The students that stand with her in choir reported that they have heard her voice while singing. The choir director has observed her mouth move but is unable to hear her voice. This teacher discouraged the students from assisting Mirta in securing permission to use the bathroom. At first, he thought that she could not speak at all, but the educational diagnostician explained that she does not verbalize needs.

Another teacher reported that she recently was able to obtain three words from Mirta. She stated that her voice was extremely weak and that Mirta preferred to hand-write responses instead of vocalizing. Further, it was reported that Mirta's writing skills are above average. Based on this teacher's clinical observation, Mirta does not engage in play with other children at school. She feels that Mirta's nonverbal behavior is due to her shyness. Mirta has never offered a reason for not talking in the school setting, although her mother says that it may be because she is attending a new junior high school campus. Mirta is mainstreamed in a regular classroom and functions academically at the level of about seven years.

Another teacher stated that Mirta “speaks with her eyes.” If she is anxious, she will let it be known by the look in her eyes. However, the teacher stated that she has very limited eye contact when someone is addressing her. Sometimes she will gesture by nodding and looking at an individual. Mirta does not use gestures if instructed to respond to questions presented to her. In addition, she usually does not exhibit eye contact when talking in school.

The teachers all reported that classmates will inform them when Mirta needs to use the bathroom by speaking for her. Once again, the teachers do not observe this exchange of information between the parties. She does not use any type of signing to convey her wants and or needs. Rather, she sometimes writes the message. The interview was conducted in May and one of her teachers stated that before Christmas vacation, she would ask if she could go to the bathroom by using a low voice, but after Christmas she no longer made verbal requests.

When the teachers were asked how others reacted to her silence, they responded that the other students in the school were very helpful and often provide input on her behalf. Furthermore, it was stated that the children respect her, and they never observe others being disrespectful to her. Using encouragement and praise, efforts were made by all teachers to stimulate communication in the education environment. An interview with one of her former speech pathologists revealed that Mirta’s cumulative record indicates that she talked a lot in kindergarten and first grade, perhaps too much.

Oralia

Oralia is an eleven-year-old, Hispanic-American female who is enrolled in a fifth grade special education classroom. She has been living at her current address for two to three years with her parents and sister. Her mother reported that she was four to five

years old when they first became aware of her mutism. Oralia has never offered a reason to anyone as to why she does not talk in school nor does her family offer a reason for her silence. Furthermore, they are unaware of its purpose. Both her mother and teacher felt they could not provide an exact reason for the silence.

In her home environment, Oralia greets relatives if told to but will not greet friends or strangers. She does not answer questions directed to her by strangers or initiate conversations with friends or relatives. She will answer questions from relatives and initiates conversation if she sees them daily. She has one uncle in particular whom she will call regularly and interact with. If strangers come to visit the home, Oralia will leave the room.

Oralia participates in activities outside the home such as field trips with her class. During these activities, she does not speak because her classmates are around, but when she goes on outings with her family she does speak. Oralia does talk at home. Her mother reports that she is moody. Some days, she is very cooperative, and other days she shows a temper and gets very mad at those around her by acting out. Oralia talks with her mother, but conversations with her father and sister are limited. She also talks with non-family members such as doctors and neighbors. If her mother requests that she ask the neighbor for something, she will do so. When the doctor directs questions to her, she will respond most of the time. When Oralia talks at home, she uses a whispered, low volume voice. If someone calls her a name, takes something from her, or strikes her she will not verbally protest. Sometimes she will cry and in other situations she will use physical force. Oralia has told her mother that she does not like school, and if she has to

talk she does not want to attend anymore. She communicates with one sister mostly, but all of her siblings talk for her outside the home but not at home.

If asked to answer the telephone, she will speak with her immediate family including her grandparents and uncle, but she will not converse with a close cousin or close friends. She will answer the telephone and ask who it is. If it is a friend from school, she will end the conversation. Her friends at school have tried to get her talk on the phone, but she refuses. The only telephone call that she will make on her own is to her uncle. Attempts have been made to encourage Oralia to talk at school with encouragement. Oralia has never received professional help for her mutism except from the school speech-language pathologist. At the time of the interview, her mother was considering taking her to a psychologist but not just to address her episodes of silence. In regard to Oralia's language development, her mother believes that she does have an articulation problem. Her teacher also inferred that she may have an articulation problem or delayed speech (which she suggested may be a cause as to why she does not want to speak at school). Her mother confirmed that Oralia was a late speaker being; almost four years of age before speaking in full sentences, but now speaks normally. She related during the interview that her daughter must be bribed with toys, food, or the opportunity to go outside in order to talk. Furthermore, her mother reported that she will not let any doctor conduct a complete physical. She protests any type of physical contact.

At the time her teacher first met Oralia, she was not surprised by the mutism because she had been informed about this to having her arrive in the classroom. Oralia would not even ask to go to the bathroom and as a result would urinate in her clothes. Her teacher demanded that she be given a classroom that was either next to a bathroom facility or a portable classroom equipped with such a facility. Her request was met and

Oralia is currently in such a room and this problem has been eliminated with behavior modification techniques and positive reinforcement.

When Oralia's mother discovered her daughter did not speak at school, her initial reaction was surprise, anger, denial, and fear. Oralia's mother has made attempts to get her to talk in school, but her father has not because she does not have a good relationship with him. Oralia's mother reported that Oralia talks with him as little as possible.

In class, Oralia will use gestures to indicate her needs. She also uses common gestures such as nodding her head for "yes," shaking her head for "no," and shrugging her shoulders for "I don't know," but these are the only gestures she uses regularly. She does use eye contact when being spoken to. In school, the teacher reported that the children are very helpful in helping her meet needs.

APPENDIX F



DEPARTMENT OF CHEMISTRY

THE UNIVERSITY OF TEXAS - PAN AMERICAN

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To: Dr. Tim Meline
Colleen Gittins

From: Ernest J. Baca, 

Date: June 9, 1995

Subject: "Elective Mutism" Proposal

I have reviewed your proposal and am approving your study through the expedited review process. Please assure that you adhere to the principle of confidentiality. In your proposal you mentioned that a set of instructions would be provided to the guardian of the participant. Please send me a copy of the information which you are providing for these individuals.

Thank you for your attention to this matter.