
DEFINITION

The following communication features essential to the diagnosis of selective mutism are described in the *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition* (American Psychiatric Association, 1994).

- The persistent refusal to talk in one or more social situations, including school. Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., school), despite speaking in other situations.
- The disturbance interferes with educational or occupational achievement or with social communications.
- The duration of the disturbance is at least 1 month (not limited to the first month of school).
- The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language acquired in the social situation.
- 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.

This disorder has previously been called elective mutism (American Psychiatric Association, 1987), but was renamed in accordance with criteria described by Hesselman (1983). It is estimated to occur in less than .8 per 1,000 of the population (Cline & Baldwin, 1994).

Historically, little attention has been paid to associated speech and language problems in children with selective mutism. Recently, however, speech and language issues in this disorder have been addressed by Baltaxe (1994), who retrospectively examined 12 years of records at the UCLA Neuropsychiatric Institute. Of the 24 patients identified as selectively mute, speech and language assessments revealed a high incidence of psycholinguistic involvement. Three quarters of those measured had articulation problems; 86% failed auditory processing measures, 60% demonstrated receptive language problems, and 75% showed expressive language deficits.

As these problems can co-occur, the presence of a communication disorder does not rule out the diagnosis of selective mutism. But, the psychological symptoms of these silent students are far more complex than can be explained by reactions to a speech disorder alone. When these symptoms persist, the speech-language pathologist must acknowledge that selective mutism lies along the continuum of anxiety disorders (Black & Uhde, 1995) and should seek psychological expertise. To make linguistic diagnoses, the speech-language pathologist will have to rely on language samples recorded on audio- or videotape at home. Then, remediation of the linguistic aspects of the problem can only be addressed once speech has been initiated in the therapy setting.

Speech-language pathologists in educational and clinical settings can be important contributors to the programs for

children who have various degrees of emotional or behavioral problems (Giddan, 1991a, 1991b; Giddan, Bade, Rickenberg, & Ryley, 1995; Giddan, Trautman, & Hurst, 1989; Trautman, Giddan, & Jurs, 1990). The UCLA findings on patients aged 3–21 years suggest that in selective mutism, the role of speech-language pathologist is particularly important as part of a multidisciplinary team.

A variety of psychological and personality features are purported to be associated with this disorder, including excessive shyness, fear of social embarrassment, social isolation and withdrawal, impulsive traits, negativism, clinging behavior, temper tantrums, and controlling or oppositional behavior. Because of the silence in certain settings, there may be severe impairment in social and school functioning. Selective mutism is slightly more common in females than in males, and the onset is usually before age 5 years, although the disturbance may not come to clinical attention until entry into school (Kolvin & Fundudis, 1981; Sluckin, 1977; Sluzki, 1983). The disturbance usually lasts for only a few months, but in some cases, may persist for several years.

In a review of the literature associated with selective mutism (Hesselman, 1983; Kolvin & Fundudis, 1981; Leonard & Topol, 1993), theories of causation include immigrant family background, significant early childhood trauma, injury that affects the mouth, and possible family secrets. Anxiety is presumed to be an underlying feature (Lesser-Katz, 1986; Black & Uhde, 1992, 1995).

TREATMENT OF SELECTIVE MUTISM

The history of treatment for selective mutism covers a broad spectrum that ranges from the psychoanalytic school of Europe in the 1800s to contemporary behavioral interventions (Labbe & Williamson, 1984). In early German literature, selectively mute children were removed from the home and placed in residential treatment centers (Lesser-Katz, 1986). A study in Norway by Wergeland (1979) described selectively mute children who were removed from their homes for periods ranging from 8 months to 3 years. Wergeland found that untreated children were better at follow-up than children who had been removed from their homes, although no differentiation was made with regard to the severity of psychological functioning of those children who were removed.

Psychoanalysis was used with some children in the past (Chethik, 1973). The theoretical premise is that children who are orally or anally fixated wish to punish their parents. They may be maintaining a family secret, displacing hostility toward the mother, or regressing to a pre-verbal stage of development. According to Krohn, Weckstein, and Wright (1992), using a psychodynamic approach is long and difficult, with a poor outcome. Atoynatan (1986) treated selectively mute children with psychotherapy, while all their mothers were concurrently involved in individual psychotherapy. He viewed the mutism as a vehicle for the mother's unexpressed hostility. Through it, he believed, the child achieves an exclusive relationship with the mother.

Behavioral therapists view selective mutism as the product of a long series of negatively reinforced learning patterns (Leonard & Topol, 1993). Behavioral approaches that use reducing anxiety about talking and/or reinforcing the child for speaking have met with some success. Treatment strategies and behavioral therapy to initiate speaking include contingency management, stimulus fading, and response initiation procedures (see Labbe & Williamson, 1984).

A type of response initiation approach was first developed and refined at the Hawthorn Center (Krohn, Weckstein, & Wright, 1992). This approach begins with a psychiatric evaluation, information presented to parents concerning selective mutism, and a brief period of therapy to develop rapport with the patient. The children in this program are given the message that it is necessary for them to speak. The therapist then schedules a complete day when parents and child are advised that the child will spend the majority of the day with the therapist. The child is then required to say one word to the therapist before leaving the therapist's office. Most children speak within 1–2 hours, and rarely, more than 4 hours is needed. After the child speaks, he or she is praised and reunited with the family. Goals are then set regarding steps to speak in school, and then the teacher may be brought in to generalize the behavior.

The literature review indicates a variety of treatment options available for selective mutism. The particular case presented here had received an initial combination of psychodynamic and behavioral approaches lasting approximately 9 months. Previous efforts to initiate speech included contingency management, which rewards speaking behavior and ignores nonspeaking behavior, and stimulus fading, which fades in a new person to a situation where the child normally speaks. In the present case, spoken language outside the home had not occurred, despite application of a variety of elicitation strategies. The primary targeted treatment approach, therefore, became response initiation (Krohn, et al., 1992).

The treatment occurred in a public school special education program for children with severe behavior handicaps (SBH) housed within a medical school psychiatry department. Within this setting, speech and language pathologists, special education teachers, psychiatrists, psychologists, and trainees from various professional arenas work together to provide treatment for individual students. A multidisciplinary team from these fields develops an individualized service plan for each child. Some children are in individual therapy, all participate in group therapy, and those who need it receive occupational therapy or speech and language therapy.

CASE HISTORY

Mimi was referred to the school program at age 8 as a second grade repeater after 3 years of silence in regular public school classes. She had not spoken to anyone outside her home since the age of 3. When she needed to communicate, she used limited gestures and handwritten notes in class. She never spoke at school, in individual

sessions, or in speech therapy sessions. In stark contrast, she communicated freely and easily at home with certain family members.

Mimi's history contains many of the elements described in the literature of selective mutism. Her biological father spoke Spanish in the home and left the family when she was young. At age 2, Mimi had a mouth trauma; she fell and cut the inside of her mouth on a metal leg of a chair and had stitches. At age 3, she was hospitalized for more than a week with a high fever. During her illness, she had many needle sticks, was frightened, and reportedly did not talk in that setting. From that time on, she never again spoke to people outside her immediate family circle. A year later, when she was 4, the family moved to another state. Mimi's mother remarried, and the family lived privately. Mimi had four older siblings and, at the time of treatment, was the only child living at home. Mimi and her mother behaved in an enmeshed fashion as most social activities included mother and daughter together. The mother frequently spoke for Mimi when they were out, and described Mimi's experiences to other people. Dependence was fostered by the mother, who continued to bathe Mimi, did not require any chores of her, and took care of many of the details of Mimi's life.

When Mimi entered the school program, she did not speak on the telephone, would not talk in public places or to some relatives, and didn't even speak to her best friend, who occasionally stayed overnight at her home. When asked why she didn't speak, Mimi wrote, "When I was little my mother told me don't talk to strangers." Mimi spoke with animation at home, as evidenced in a videotape recorded by her mother.

Speech and language skills were an issue in this case, although early communication milestones were reportedly normal. At age 9, Mimi demonstrated, on the home video, significant syntactic and phonological error patterns that included distortion of /l/ and /r/ phonemes; omission of /s/ in plurals, possessives, and present tense verbs; and immature syntactic structures (e.g., "This a boy.... This one name Andy.... I'm gonna talk about what family do"). Because of her mutism, these problems had never previously been addressed in therapy. Her pragmatic deficits were significant. As a non-speaker at school, she lost all opportunities to inquire of others, to set the conversational agenda, or to extend an idea relative to her own experience. Others were forced to be questioners while expected responses from Mimi were reduced to head nods and shakes for "yes" or "no."

Mimi's limited participation in school, along with her linguistic deficits, placed her at great risk academically. At age 9, while she should have been in the fourth grade, she was a third grader performing at the second-grade level in reading, spelling, and math.

The Multidisciplinary Team

The multidisciplinary intervention program in place for Mimi included services inherent to this psychoeducational treatment program, set in a medical college training site.

The classroom teacher had special education certification and was assisted in the eight-student classroom by an aide. Twice weekly developmental therapy group sessions within the classroom were jointly led, at first by the speech-language specialist and the teacher, and then later by the psychologist and the teacher. Individual psychotherapy was provided by the psychologist while twice weekly speech-language therapy sessions continued.

Throughout the week, determination of goals, assessment of progress, and interactive strategies were discussed at weekly team meetings as well as informally. Progress made in one setting was then transferred to the next. For example, as soon as whispering was achieved in psychotherapy, the teacher and the speech-language pathologist let Mimi know that they expected to hear whispered speech as well, and would provide much coveted "dyno-bucks" as a reward. Dyno-bucks were part of a token economy system the teacher used in a weekly auction for prizes. Once whispering had become predictable, the speech-language pathologist began articulation and syntactic interventions. When Mimi seemed comfortable whispering to her classmates, some were invited to join her in sessions with the psychologist and with the speech-language pathologist.

By coordinating efforts, maintaining consistent reward systems, and complementing each other's programs, the professionals, working with Mimi's parents, were better able to help her move gradually toward speaking in school. Her parents attended quarterly clinical treatment team conferences where her individual service plan was updated. As they provided information about changes at home, team members were able to encourage further expansion of social opportunities and excursions beyond the realm of the immediate family to increase speech and to generalize it to other situations.

Psychologist's Observations

Mimi had originally been seen therapeutically by her public school counselor, with no success. After being referred to the off-campus SBH program, she was first treated for approximately 10 sessions by a child psychiatry fellow. Therapy involved meeting with parents and other family members, a home visit, and trips out in the community as rewards for achieving set goals. Throughout this therapeutic experience, Mimi made progress in nonverbal communication skills, such as participating in pantomime activities in the classroom, attending with eye contact when spoken to, raising her hand more frequently in class, and using more appropriate gesturing. However, no progress was made in vocalization.

At the beginning of the second year in the SBH placement, Mimi's therapy was taken over by a psychologist. Stimulus fading was initiated as Mimi called the therapist from home and reported on voice mail. Early therapy sessions involved building rapport and communicating by writing notes or writing on the chalk board. Table 1 describes the progression of therapeutic interventions in this case.

Within a month, the therapeutic approach shifted to a response initiation, as described by Krohn et al., (1992) at

Table 1. Progressive therapeutic interventions.

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1. Establish rapport.
 2. Gain speech via escape/avoidance technique.
 3. Provide daily, systematic rewards.
 4. Use multiple sites for interventions.
 5. Persistently increase demands.
 6. Maintain a close, empathic relationship.
 7. Vary interventions across sites.
 8. Allow the child to choose behaviors.
 9. Use creative approaches at stalemates.
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the Hawthorn Center. One day was chosen when, with mother's approval, Mimi would remain at school until she spoke to her therapist. During this long session, which lasted approximately 4 hours, Mimi alternately became very sad, sat curled up in a ball near the door, sobbed, and hid under a chair. She communicated with her therapist by writing notes, and tried to bargain by writing, "I promise I will talk Friday." Finally, near five o'clock, she agreed to whisper, "I want to go home." She also called her mother from the office phone and asked her to come to drive her home.

Following this initial whispering, Mimi's verbalizations were expanded by having her choose things to say. The therapist would prepare individual 3" x 5" cards with messages Mimi chose printed on them. Mimi agreed to whisper with her speech-language pathologist, her classroom teacher, and an aide, and eventually with many others in the school environment. As generalization occurred, other students became part of the therapy and she whispered to them. She and the therapist also wrote a puppet show that they presented to the class. Finally, Mimi became involved in the day-to-day communication within her class. She raised her hand to contribute verbal information, she participated in group discussions, and she read to others, but she persisted in using a whisper.

After several months, the therapy began to involve shaping. Mimi was encouraged to use other vocalizations—to cough, to make sounds with a kazoo, and to produce animal sounds for the puppets. When the idea of another long day to elicit voice was offered, she resisted. Instead, she agreed to use voice in speech sessions and occasionally in class to earn the special dyno-bucks.

Although Mimi continued to speak most often in a whisper, she gradually began talking in full voice on more occasions at the initiation of a response cost technique. Mimi and her therapist composed a list of responses she would give in a "normal" voice each half hour. Some were brief, like "please" or "thank you," and some were extensive, such as reciting the spelling list. If Mimi did not use normal voice, she lost one class point each half hour. Losing class points meant she could not earn special prizes or a Friday event that was an established part of the SBH ritual in this classroom. Homework assignments were added to further generalize her use of full voice. Dyno-bucks, continued as rewards, were contingent on Mimi's speaking in community settings, with her mother reporting her successes. Later, this expanded to her speaking to one more person beyond school and home each day.

Once Mimi was talking in multiple settings, she was introduced to the idea of returning to her home school for the fall term. The home school personnel were consulted and information was shared about her case with the special education teacher and the speech-language pathologist.

Classroom Teacher's Observation

Each person working with Mimi influenced her case in a unique way. Her teacher saw that in a classroom of children with difficult behaviors, Mimi was at first inadvertently rewarded for not talking, as she earned class points for following classroom rules, even though she was mute. Her classmates reinforced, supported, and enabled her silence by speaking for her, explaining to strangers that she was "just shy," and becoming protective of her silence. Then, when the behavioral treatment plan was organized by the multidisciplinary team, the teacher worked with the psychologist, psychiatrist, and speech-language pathologist to determine what rewards would be meaningful to Mimi and what her goals should be. Rewards for specific behaviors, such as raising her hand, nonverbal participation, and writing notes were established initially.

Mimi was a willing helper in class and was well-liked by students because of her nurturing and sharing nature. The other children reacted to her silence in interesting ways. Some students began to beg her to talk, some offered her rewards for talking, and some tried not talking, to be like her. Occasionally, the students and teacher would become frustrated with her silence. These reactions evoked in others by her disorder were in evidence throughout the school year. When Mimi's first year in this specialized setting ended, the teacher felt disappointed because Mimi had not begun to speak.

During the second school year, Mimi became more involved in peer interactions and all classroom activities. Once she began whispering, she became more animated, was eager to participate, and shared personal information with her classmates. As she began to use a full voice, her communication efforts increased further and she became a total participant in all activities. She also significantly increased her academic performance. The teacher shared her feelings of success.

Speech-Language Pathologist's Observation

The speech-language pathologist saw Mimi in individual sessions twice each week. Her efforts paralleled initial developmental therapy goals for Mimi, which focused on nonverbal communication in class group work. Table 2 describes the progression of therapy.

In speech therapy sessions, Mimi was at first encouraged to use gestures. When pantomime activities and guessing games about themes like sports and emotions were offered, Mimi willingly participated and seemed to enjoy acting things out. She began to nod for "yes" and "no." Other students became involved in a game of "Guess Who?" as a means of initiating nonverbal communication, regulating other's attention, and taking turns, but Mimi still did not

Table 2. Progression toward vocalization.

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1. Written messages
 2. Gestures
 - head nods
 - pantomime
 - individually
 - with others
 3. Private tape recordings
 - reading stories
 - voice-mail
 - conversational responses
 4. Whispering
 - printed messages
 - simple responses
 - to psychotherapist
 - to speech-language pathologist
 - work on articulation, morphology, and syntax
 - to classroom teacher
 - to classmates in psychotherapy session
 - to others in school
 - puppet show
 - in psychotherapy session
 - with another child
 - in the classroom
 5. Loud whisper
 - in all previously whispered situations
 6. Vocalization
 - animal sounds (puppets)
 - coughing
 - kazoo
 7. Soft voice
 - in all school situations
 8. Full voice
 - in school
 - beyond school
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initiate communication. She did use paper and pencil to communicate, but because her skills were limited, this was unwieldy.

On a suggestion by the speech-language pathologist, Mimi began to tape messages and read stories into a tape recorder. But, she would only record her voice while the therapist was outside the room. They listened together as this tape was replayed, and the speech-language pathologist could then respond.

Once it was established that Mimi could communicate in an audible whisper, speech therapy goals focused on correcting articulation, morphology, and syntactic errors. Rewards were used consistently, and she gained dyno-bucks if she participated by whispering. Mimi joined with another student in question and answer games and activities using a visual barrier to encourage verbal description. She became more animated in her conversational exchanges over the following weeks, while her volume increased.

Once whispering had begun, Mimi became an animated and eager participant in her classroom and in other school settings. She even whispered loudly into the intercom to alert the office to the arrival of the school busses. Dyno-bucks were offered for specific speaking goals each day,

with Mimi assisting in setting up the tasks. Targeted tasks were gradually wider use of speech, more substantial verbal interactions, and increasingly greater volume.

By the spring of the second school year in this setting, Mimi was using full voice at school and in the community. Plans were made for her return to her neighborhood school the following fall. Full voice was maintained over the summer months, accompanied by new social experiences with neighborhood children, and success has continued in her regular education setting. She now speaks with ease at school and in social situations in the community.

CONCLUSION

Because selective mutism appears to be a communication disorder, children who do not speak in school are commonly referred to speech-language pathologists. However, we have seen on closer inspection that selective mutism is actually a pervasive psychological problem, supported and maintained by the child's history, family, and environment. Therefore, a comprehensive treatment strategy requires a complete behavioral assessment and treatment that is matched carefully to the client (Dow, Sonies, Scheib, Moss, & Leonard, 1995; Labbe & Williamson, 1984).

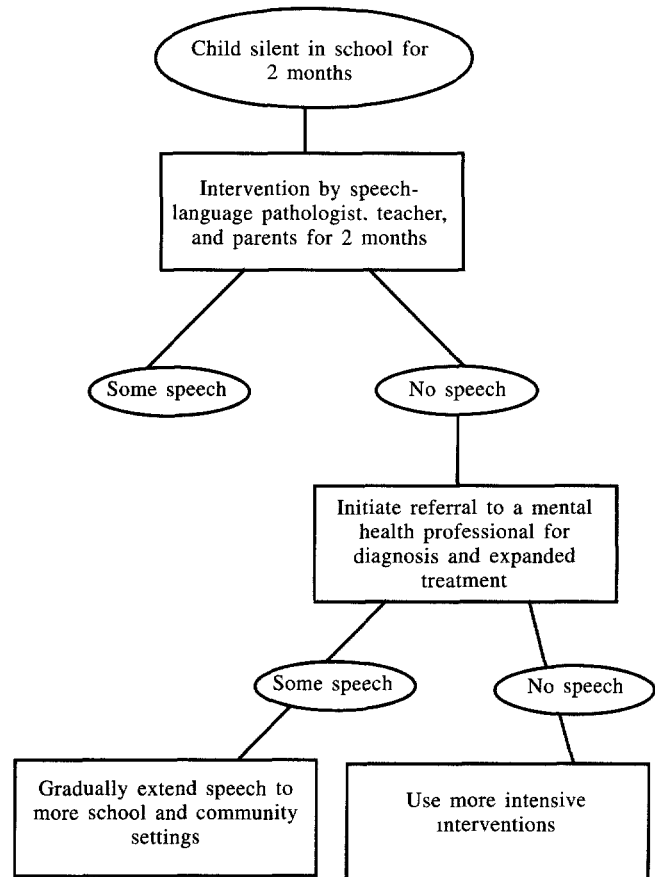
The following guidelines are suggested for speech-language pathologists working in school settings (see Figure 1).

- If more than 2 months have passed with the child not speaking in school, a speech-language pathologist should begin intervention in collaboration with the teacher and the parents.
- If no speech is heard after 2 months in speech-language therapy, a referral should be made to a mental health professional who has had some experience with this disorder, and who can form a diagnosis and become involved in the treatment.
- As soon as speech begins, the treatment programs should broaden to include many facets of the child's life and many more people, including other teachers, secretaries, bus drivers, and cafeteria workers.

A concerted effort must be made to stimulate speech, because the longer the child is silent, the more entrenched the behavior becomes. The mental health professional, along with the speech-language pathologist, teacher, and parents, are all necessary for effective treatment. Course of treatment is unpredictable because it is based on the length of time the behavior has existed, the personality factors of the child, and the willingness of the significant others in the child's environment to focus on this problem.

This case example illustrates for speech-language pathologists the advantages of expanding services to a multidisciplinary team, especially when the disorder is complex and deeply ingrained. The psycholinguistic expertise provided here by the speech-language pathologist guided the direction of the progression from nonverbal to vocal expression, as indicated in Table 2. The psychologist provided the initial breakthrough to speech, emotional

Figure 1. Guidelines for management of selective mutism in an elementary school setting.



support, strategic guidance, and daily intervention. The classroom teacher managed the intricacies of the reward system in an ongoing academic and highly communicative context. Carry-over to the home setting was a concerted effort, still based on dyno-buck rewards for speaking in the community and to other relatives.

The impact of a daily routine, multiple service providers, a treatment team plan, and flexible collaboration cannot be overstated. Despite the fact that selective mutism appears to be a problem with communication, speech-language pathologists are advised to seek additional professional support when working with children with this complication.

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