

Hits and Misses: Interventions in a Case of Selective Mutism

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A child diagnosed with Selective Mutism misses out on several developmental tasks including social interaction and academic growth, which are a significant part of childhood. Psychological literature based on particular theoretical models suggests a range of therapeutic strategies to deal with this specific anxiety disorder. A case of a six-year-old girl is discussed for whom a series of interventions were employed. Exploratory findings appear to indicate that therapies such as art and puppet therapy are not effective because such approaches require self-expression from the child, which in theory is precisely what is painful for a selective mute. On the other hand, other strategies are found to be effective, with each strategy contributing uniquely to ameliorating particular symptoms. Specifically, physically vigorous play therapy reduces anxiety symptoms, while computer-based interventions appear to be successful in increasing verbal behavior. The theoretical foundations for the different strategies utilized are also discussed.

Keywords: *selective mutism, play therapy, computer-based interventions*

Selective mutism (SM) is characterized by the DSM – IV TR as the “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”(American Psychiatric Association, 2000, p. 127). To be considered a disorder, the individual’s symptoms must interfere with educational or occupational functioning, or with social interaction. The symptoms must have been present for a month and cannot be limited to the first month of school. For SM to be diagnosed, it must be distinguished from other disorders such as autism, developmental disorder, schizophrenia, among other things (American Psychiatric Association, 2000). Similarly, it should be differentiated from biological ailments such as deafness, wherein the individual may be physically unable to speak, rather than psychologically.

Selective mutism has been considered a severe form of social anxiety disorder (Kearney & Vecchio, 2007; Standart & Le Couteur, 2003), wherein

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the onset is between the ages three and eight (Klin & Volkmar, 1993). Children with SM have a marked fear of social situations, particularly a fear of being negatively evaluated by others. Because of the environmental circumstances, selective mutism is often diagnosed once the child is in school. Anstendig's (1998) literature review discusses several personality and comorbid features that often come with the disorder. These include shyness, oppositional or controlling behavior, and trauma during prenatal development, premorbid speech or language abnormalities, mother-child interdependence and overenmeshment, and a history of family anxiety disorders, among other things.

The goal of this article is to present a case study of a client diagnosed with SM and the various interventions utilized by this investigator. This study uses an exploratory case study design and therefore does not utilize stringent controls across the implementation of therapies, as would be present in an evidence-based intervention study. The interventions described are divided into phases, reflecting the time sequence of different strategies. As such, the history variable of the success or failure of the interventions cannot be eliminated.

REVIEW OF INTERVENTIONS BY THEORETICAL FRAMEWORK

The literature suggests a variety of interventions to deal with selective mutism. These treatments are based on specific theoretical modalities that frame and explain its etiology and course. These include the psychodynamic, behavioral, and cognitive behavioral perspectives. There are also comprehensive family, school-based, and pharmacological interventions, but they are beyond the scope of the exploratory findings of this study, and hence will not be discussed in the literature.

Psychodynamic Interventions

The psychodynamic perspective on selective mutism suggests that this disorder is caused by significant intrapsychic conflict. The goal of intervention is to deal with these conflicts, after which the symptoms of selective mutism will consequently be eradicated. Specific treatments include art and play therapy, among other things.

Art therapy. As suggested when providing interventions for children in general (O'Connor & Braverman, 1997), and SM in particular (Krysanski,

2003), art therapy is considered an appropriate treatment modality for this developmental stage. One reason is because they are familiar with art materials. Furthermore, the nonverbal nature of creative expression is appropriate for a child's cognitive level. The psychodynamic model suggests that expressing unconscious issues in an indirect and safe manner such as drawings using paint, crayons, paper, clay, and other materials will provide catharsis for and healing in the client.

Play therapy. Psychodynamic literature also suggests that anxious symptoms are conceptualized as the ego's response to the threat of a traumatic situation (Taylor & Arnow, 1988). Much of the energy within a person's psyche is dedicated to preserving ego boundaries. In the case of SM, the individual expends much of his/her unconscious energy in protecting him/herself from potentially dangerous and anxiety provoking situations such as communicating with others. As such, the goal of play therapy is to refocus this energy into play, thus lowering the child's dysfunctional defenses (O'Connor & Braverman, 1997). Depending on the age and interests of the child, specific tools that have been utilized include dolls or other figures, board games, and physically vigorous activities.

Behavioral Interventions

This model conceptualizes selective mutism as a behavior that is learned. This perspective suggests that the symptoms are maintained by influences in the environment. As such, strategies focus on environment-based interventions and behavior modification to increase verbal communication (Anstendig, 1998). Under the umbrella of the behavioral model are several specific interventions.

Contingency reinforcement. This focuses on basic behavioral strategies, specifically, reinforcement of verbal behavior, and non reinforcement of nonverbal communication such as shaking one's head (Labbe & Williamson, 1984). This kind of intervention suggests finding the right kind of reinforcement and providing it consistently across situations and environments.

Stimulus fading and hierarchical exposure. This strategy involves expanding the environment wherein the child is comfortable to speak. It begins with the environment in which the child is comfortable and verbal and gradually exposing him or her to various situations and circumstances that are a little more anxiety provoking. In one treatment strategy, Grover, Hughes, Bergman, and Kingery (2006) suggest a technique by which a

child may practice speaking with his/her parents alone in the therapist's office, and then the therapist eventually steps in while the parents are still present. Then, when the child becomes comfortable with the therapist, the parents step out. The rationale of this approach lies in several strategies under the behaviorist model utilized for the treatment of phobias, namely shaping and counterconditioning (Hopko, Robertson, Widman, & Lejuez, 2008). A variant of this intervention involves bringing other children (such as classmates) into the home, where the child speaks. Then, when the child is comfortable with speaking with her classmate, then they might start communicating in other places, and eventually with other classmates (March, 1995; Moldan, 2005).

Video self-modeling. This intervention involves making a video of a child, talking with a parent and edited to appear as if the child is answering the questions of her teacher or therapist (Anstendig, 1998). This allows an opportunity for the adult to positively reinforce the child's voice and ideas.

Cognitive Interventions

The cognitive perspective suggests that the etiology of SM is rooted in dysfunctional thinking processes. These cut across various cognitive processes such as attention, memory, or problem solving. As such, therapy focuses on changing the client's way of thinking (Kumpulainen, 2002).

Puppet therapy. This is a kind of play therapy that focuses on problem-solving interventions. Hall, Kaduson, and Schaefer (2002) suggest that "this technique is particularly effective for any children between 4 and 8 years who are anxious and withdrawn at the beginning stages of therapy" (p. 521). Hall and colleagues recommend that puppets are presented as having the same problem as the child, and the goal is for the child to help brainstorm ways by which to solve the problem.

Challenging dysfunctional thinking. Rapee, Wignall, Hudson, and Schiering (2000) suggest that replacing intrusive anxious self-statements with coping self-statements can be taught to children with selective mutism. Children are given self-instructional training to catch themselves when such dysfunctional thinking occurs. Grover and colleagues (2006) suggest making an effort in terms of memory strategies: to recall past successes in anxiety-provoking situations when faced with a potentially fearful new situation. Lastly, individuals with anxiety disorders, especially social anxiety, are characterized as having *self-focused* attention. Whereas other people are more attenuated to the environment, persons with SM appear to have a

mental representation of the self as the main focal point of their attentive energies (Schultz, Heimberg, & Rodebaugh, 2007). Hence, the goal of cognitive therapy is to teach the client to shift her attention from the self to the environment.

Selective Mutism in the Philippine Context

To date, there are few case studies on interventions for selective mutism in the local setting. Alcala, Bautista, and Tarroja (2010) present their findings on the profile of 15 children with selected mutism, and suggest cognitive-behavioral therapy and family- and school-based interventions as possible strategies for gradually reducing symptomatology. Studies on interventions with children with other psychological disturbances show an array of approaches including music therapy (Marin, 2004), art therapy (Carandang, 1987), and play therapy (Carandang, 2009).

CASE REPORT

Reason for Referral

Nicola (not her real name)¹ was referred for therapeutic intervention² around the second quarter of the second grade, due to excessive shyness in school. When called on for recitation, she would respond, but in a very soft voice, if at all. She almost never engaged in conversation with her classmates, neither initiating nor responding. She often sat by herself between classes and during breaks, never joining in recreational play. In contrast, at home and with relatives, Nicola was a talkative, playful six-year-old. Her mother recommended her for psychological intervention because, while her grades in written subjects were very high, she was failing on class requirements that needed verbal communication and social interaction. Furthermore, her mother was concerned that she was missing out in terms of building friendships and enjoying interpersonal activities at school. The symptoms had been evident since she was in the first grade.

Family Background

Nicola is the younger of two siblings, her sister being in high school. Her mother was employed at a large corporation whereas her father was self-employed. Nicola was very dependent on her mother. Her mother

accompanied her to school daily, staying at the back of the classroom until the school bell rang to signal the start of class. According to her mother, her father had a history of clinical depression. In fact, while therapy was ongoing, her father was on medication, and spent much of his time at home rather than at work. Nicola's sister was described as being very sociable and less of an academic achiever compared to her younger sibling.

Academic Background and Daily Functioning

Nicola attended kindergarten 1 when she was four years old, at a private preschool. She transferred to Kinder 2 at her current school when she was six years old. In the preschool, Nicola was at the top three of her class of 15 students. Nicola's academic strengths were in Mathematics and Reading. Her mother described her as a self-starter in the sense that she does homework on her own without being prodded.

Nicola watched television when she comes home from school. She especially liked cartoons. She also liked painting and drawing, or playing imaginary games. She also engaged in computer games. Often, she enjoyed playing with her sister. Her extracurricular activity included violin lessons which does not require her to talk to her instructor or to other children at the music center.

In school, Nicola's personality has changed through the years. In Kinder 1, Nicola was very lively. She had a best friend and was the leader in their year-end school program. In her second year at the preschool, her teacher noted that she was significantly quieter. She also was less friendly with her classmates. When she entered her present school she became even more silent, neither initiating nor responding to her classmates.

Nicola was also very shy in other social activities. She disliked children's parties and, if forced to go, would not interact with other children. She sat quietly beside her mother throughout the event.

At home, Nicola was lively and energetic. She was noisy and relaxed with close cousins. On the other hand, she was of a sensitive and jealous nature. Often, when people around her are laughing, she would think that they are talking about her and this would provoke her to get angry. She also had difficulty taking criticism.

Initial Behavioral Observations

During initial sessions, it took significant prodding from her mother for Nicola to accompany the therapist to the therapy room. Nicola would often

peek outside the door to check if her mother was there. Later, these opportunities to check were regulated in the middle of the session (after half an hour), and Nicola complied accordingly.

In the first several sessions, Nicola was silent. She never verbally responded to the therapist's questions or comments, and only rarely did she nod or shake her head. Furthermore, when in the therapy room, Nicola stood beside a chair, looking at the therapist occasionally, but not moving. Her head was slightly bowed down, and her hair covered her face. She did display significant finger flicking behavior, an aberrant motor activity common among children with SM (Hayden, 1980). She showed little emotional expression. After a few sessions, she eventually sat down on the chair or rug, but the other behavioral manifestations remained.

Phase 1: Traditional Expressive Therapies Explored

The therapy room displayed different kinds of toys including puppets, tea sets, dolls, and balls. Nicola did not pick up or play with any of the toys. There were also different kinds of art materials such as crayons, paint, clay, scissors, and colored paper. Nicola did not even go as far as handle or even look at the materials. She remained standing beside her chair, not moving.

Realizing this pattern, the therapist, in the next session, decided to play with the materials herself, and allowed Nicola simply to become comfortable and observe. This therapist engaged in art, drawing, coloring, cutting, and the like and showed Nicola different kinds of art techniques that she said Nicola might want to try at home. After two sessions in which Nicola showed no change in her behavior, this therapist used puppets to tell stories. From her behavior in the sessions, and her mother's feedback, it appeared that Nicola was more positively engaged and responsive to the story telling. In these sessions, Nicola was observed to be looking more at the therapist, and her body language was more geared towards the activity, with the client sitting nearer to the therapist, and leaning forward. Furthermore, her mother would say that Nicola liked these sessions. This was in contrast to the expressive art sessions, where Nicola complained to her mother that those sessions were "boring." Notably, however, Nicola still did not express herself verbally and her face remained unemotional.

Phase 2: A Behavioral Intervention Explored

After two sessions of puppet story telling, a behavioral strategy was implemented. To make Nicola more comfortable in therapy, her cousin Janice

was invited to participate. Janice, a ten-year-old female, is the cousin whom Nicola was closest to.

This strategy was successful and rather dramatic in eliciting communication from Nicola. In the first session in which her cousin participated, Nicola almost immediately picked up the art materials as her cousin did when asked if they would like to draw. She started immersing herself in the different art activities, as well as giggling and making short comments (e.g., "*hay naku!*"; "*hindi, hah!*"). Notably though, she observed what Janice was doing for around five minutes before she began her own work. This phase of watching others before drawing would continue to play itself across several sessions. Furthermore, she often erased, crumpled, or revised her artwork. Thirdly, she did not seem to show pride in her work, making remarks like "*pangit ito*" (this is ugly) or "*gawin natin ito, ay huwag nalang!*" (Let's make this... no never mind). In some sessions in which Janice could not make it, it would be noted that Nicola was inclined to copy what her therapist drew. When Janice's participation ended, Nicola reverted back to a shy demeanor, minimal spontaneity, and narrow range of emotional expression, although she retained her verbal behavior of making short reactive statements. Notably, these statements were usually comments about the therapist's grammatical or pronunciation mistakes.

Phase 3: Physical Activities

Together with art therapy, another intervention strategy was introduced to Nicola while Janice was still involved. This was a series of highly active play activities. In particular, Nicola engaged in timed treasure hunts wherein she would have to hunt for and decipher a series of clues around and outside the clinic until she found the treasure. In the open spaces, Nicola excitedly ran around looking for the clues. After several of such activities, Nicola was not only much more active, but she also became even more verbal and emotionally expressive. She became occasionally proactive rather than merely reactive in conversation, asking questions, making a joke or expressing remarks spontaneously. Notably though, when her cousin would remark about her making conversation (e.g., "*uy, she's talking!*"), Nicola would become self-conscious and be quiet for a while. She also became more spontaneous with her therapist between sessions, occasionally tickling her, playing hide and seek, or surprising her in the corridors. Nicola clearly enjoyed the treasure hunt sessions and requested for more of them. These continued for several more sessions after Janice left.

Phase 4: Computer Technology as an Innovative Tool of Intervention

Knowing this client's interest in computer games and chatting, the therapist utilized three experimental strategies. First was the use of *Photobooth*, a program on the computer, *MacBook*. *Photobooth* works as a camera, with the lens at the top of the screen that instantly produces pictures on the screen. Furthermore, it has an added feature called *effects* that can manipulate the pictures so that the figures look *warped*, *dented*, *squeezed*, or *stretched*, among other things.

When *Photobooth* was introduced, Nicola's reaction was laughter. She started actively manipulating the mouse of the computer to try different effects on her face, that of her cousin Janice, and this therapist as well. Furthermore, she spoke more spontaneously and proactively, sharing her reactions to the different unusual outputs and stating her preferences for specific effects. It was with this activity that Nicola did not exhibit the symptoms of SM at all.

The positive outcomes of this technological intervention led this therapist to utilize two other computer programs. This therapist started communicating with Nicola, both in sessions and afterwards, through *Yahoo Messenger*, an application that allows its users to send and receive picture, written, and spoken messages. This therapist would occasionally write Nicola, greeting her casually with a "hi" and "how are you?" Nicola was very expressive, talking about her activities, many sentences clearly emotionally charged with exclamation points and capital letters (e.g., "OH MY GOSH, Teacher, IS THAT YOU!?!").

Another technological intervention was to use the *Powerpoint*, a program for making presentations. This therapist introduced it to Nicola after the success of the use of *Yahoo Messenger*. Clearly a computer-based kind of expressive therapy, Nicola spontaneously created stories by typing them on the computer and embellishing them with *Clip art*, a program of premade images used to illustrate various mediums. One such story that she made was that of her birthday party. She wrote of going out of town with her cousins, of the games they had in the pool and the prizes she won, of the food they ate, and of how her cousin's lollipop broke. This narrative was decorated with the corresponding clip art. These interventions were implemented for around a month.

In the course of several months of therapy, Nicola's mother began noticing changes in her daughter's behavior. Soon, she allowed her mother to wait outside the classroom while waiting for classes to start. Eventually,

Nicola agreed that it would be her nanny waiting outside instead of her mother. Soon after, the nanny waited in the parking lot then Nicola started talking occasionally with the classmates who sat around her in the classroom. She started to recite, although not often, and with a very soft voice. Therapy ended after around six months of *on and off sessions*, when scheduled school exams and holidays intervened, and Nicola's mother decided that she would forego therapy temporarily.

DISCUSSION

Anstendig's (1998) review on the treatment literature on selective mutism suggests that practitioners and researchers disagree on the single best strategy for intervention for the disorder. She states that there appears to be a variety of methodologies based on different theoretical models, and that many of them are found to be effective. Anstendig also points out that an individualized program should be created for each client, depending on the developmental level, personality, and history of the client.

In the case of Nicola, the use of expressive therapies namely, art and puppets play, appeared ineffective. Despite the literature findings on such strategies for this developmental stage, these methods did not seem to help symptom alleviation. The problem with these kinds of approaches is that these project the client to, as the name states, express herself. Unfortunately, a core symptom of SM is a difficulty in self-presentation. Self-presentation is defined as an attempt to control one's self image in front of others (Schlenker & Leary, 1985). Clients with SM and other anxiety disorders have a difficult time expressing themselves because they do not know how to go about creating a specific impression, or are afraid to project a wrong or inappropriate one. It is possible that, in expressive therapy, Nicola was constantly facing an unstructured situation, and did not know how to react. This can be further illustrated in certain sessions, when Nicola did draw; she would invariably copy the output of those around her. Despite her social anxiety, Nicola performs in school concerts as a violinist. The difference is, in those situations, the notes on the pieces are defined. In art therapy (and in social situations), the requirements are not clearly outlined.

The case studies discussed by Crenshaw (2007) and Moldan (2005) illustrate the pitfalls when making a selective mute child express him/herself verbally. They emphasize that this only puts pressure on the child, and builds up even more anxiety. Their findings suggest veering away from making the child speak early in the intervention. This then may also be generalized to other forms of self-expression.

On the other hand, some behavioral interventions like counter-conditioning, modeling, and stimulus fading appear to lessen symptoms. Specifically, including Nicola's cousin in some sessions makes a difference. Janice serves as a positive stimulus that was presented alongside an anxiety provoking social situation. Because the social support elicited positive feelings, the anxiety from the social circumstances diminishes significantly. Furthermore, Janice serves as model that Nicola imitated. By observing her actions and seeing its positive consequences, Nicola exhibits the same behavior. Lastly, social support serves as a kind of generalization strategy and helps the client expand her comfort zone from the home to the larger environment, lessening symptomatology across a range of circumstances, even when the positive stimulus faded (Moldan, 2005). This strategy has been evaluated as beneficial across the literature, with different close individuals (i.e., a classmate, parent, teacher) serving as the positive stimulus (Giddan, Ross, Sechler, & Becker, 1997; Moldan, 2005).

Gross physical play also proves beneficial, specifically for alleviating anxiety symptoms. This can be explained through several theoretical perspectives. From a psychodynamic point of view for example, physical play appears to lessen Nicola's physiological and emotional over control and guardedness. By letting down her dysfunctional defenses by expending the energy on strenuous play, Nicola becomes spontaneous, uninhibited, and expressive. From a cognitive perspective, Nicola deviates attentive resources from over self-consciousness to the external environment. In doing so, this dysfunctional cognitive preoccupation diminishes the level of her symptoms.

Lastly, the use of computer technology also alleviates anxiety symptoms while directly addressing the goal of eliciting verbal and emotional communication. The use of various programs proves beneficial as toy for play and a communication tool.

According to Fromme (2003), the computer has taken a dominant position in the lives of children and has become a substitute to other play activities such as reading or sports. As such, it may be said that children find the computer as a comfortably familiar play tool. While children of past generations spent leisure time playing with dolls, or doodling with crayons, this generation has the computer as an attractive alternative for after school hours. If an interventional goal of psychodynamic play therapy is for the child to have a sense of enjoyment and lower defenses, then it makes sense to use the tool they are used to and find entertaining. It may even be said that crayons, scissors, and glue are conceptualized as part of the school paraphernalia more than play, and also related to school grades

and being evaluated. Considering that Nicola is an academic achiever, the seeming lack of interest and avoidance of such materials is understandable. Consequently, the use of computer programs as an expression of underlying intrapersonal conflict is also beneficial, precisely because Nicola's defenses were lowered.

In terms of being a tool for dialogue, a study on online communication reveals that part of the power of Internet communication is the sense of control the individual has over what he or she reveals (Subrahmanyam & Greenfield, 2008). The control comes from being able to spend time contemplating what one will disclose, without feeling pressured. A local survey done by Abregana, Ubarde, and Valbuena (2003) on Filipino college students reveals that computer technology is now a tool for communication for youth to self-close and explore their identities. The struggle of individuals with SM is the pressure by societal dynamics to speak spontaneously (Moldan, 2005). Through on-line social network chatting opportunities, the person with SM has time to reflect on, type out, edit, and reedit her verbal exchanges. This becomes a social skills training application, another intervention suggested for social anxiety disorders, a practice arena before interacting in public (Schultz et al., 2007).

LIMITATIONS AND RECOMMENDATIONS OF THE STUDY

The general shortcoming of this study may be due to its design. Because it is an exploratory single case study, several limitations are inherent. One is the lack of generalizability of the findings. What worked and did not work with the client in this study may not be true for other cases. Notably though, the literature emphasizes individualized interventions for cases on selective mutism (Grover et al., 2006). Another limitation is the history variable which makes it difficult to categorically determine the most effective intervention strategies. It is recognized that the latter interventions might be the more potent strategies simply because they were used at a later time in the therapeutic process. In contrast, the relationship between the strategy and the specific behavioral outcomes makes for a good argument for the success of the intervention. Third, there admittedly is an overlap among strategies. Social support is present during several of the various interventions. Hence, the independent contribution of each strategy cannot be clearly delineated.

It is recommended therefore to use more experimental designs for further studies. Recruitment of more subjects, isolation of variables, and utilization

of a balance in variable schedules, are some suggestions for the improvement of the study.

Another limitation rests on the practical application of one of the interventions. It is acknowledged that the use of computer technology is limited to those who have access to a computer. Hence, this strategy will be less readily accessible for clients in the lower socioeconomic bracket.

CONCLUSION

Selective mutism is a difficult disorder to remedy. Therapists should be open to exploring a range of theoretical frameworks and strategies to allow anxious symptomatology to diminish and improve verbal communication. This study has made initial steps in the research of possible interventions that can improve a client's condition.

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NOTES

¹My client's family consented to her case being discussed in this study. They were informed that the client would remain anonymous and that specific information would not be linked to her identity.

²Guidelines for ethical conduct in therapeutic interventions were followed.

