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## **CONCURRENT INDIVIDUAL AND FAMILY THERAPY IN A CASE OF ELECTIVE MUTISM**

### **ABSTRACT**

In this paper, following a literature review, a family containing a child who had been electively mute for four years is described. A concurrent programme of individual and family therapy and the systemic hypothesis which guided these interventions is then presented in detail. Behavioural and psychometric data are presented to illustrate the dramatic improvement which the identified patient showed over the course of treatment. Finally, the probable mechanisms underpinning the child's improvement, and how these differed from our initial expectations, are discussed.

### **DEFINITION AND INCIDENCE**

Elective mutism, a condition first described by Tramer in 1934, is characterized by a refusal to speak to anyone except a small group of intimate relatives or peers for a substantial period of time, e.g. six months. The condition is also known as selective mutism. Persistent elective mutism is rare and estimates of incidence range from 0.3-0.8 per 1000 (Brown & Lloyd, 1975; Fundudis et al., 1979). The condition usually develops between the ages of three and five years but is typically noted when the child first enters school and refuses to speak with teachers or classmates (Elson et al., 1965).

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Unlike other language disorders, elective mutism is slightly more common in girls than in boys (Kolvin & Fundudis, 1981; Wilkins, 1985).

Elective mutism should be distinguished from mutism secondary to conditions such as mental retardation, developmental language delay, hearing loss, psychosis or hysterical aphonia (Cantwell and Baker, 1985). A distinction should also be made between elective mutism and low-frequency or reluctant speech (Sanok and Ascione, 1979). The condition holds many features in common with other emotional disorders of childhood, but is distinguished from them by a variety of features also. For example, speech difficulties and maternal overprotection are more common among elective mutes (Wilkins, 1985)

#### **ETIOLOGICAL THEORIES**

Theories concerning the etiology and maintenance of elective mutism may be loosely classified as family-oriented, psychodynamic or behavioural. What follows is our synthesis of the more important ideas in each of these conceptual domains. Review papers by Cunningham et al. (1984) and Hesselman (1983) may be consulted for a more detailed appraisal of the theoretical literature and extensive bibliographies .

According to family-oriented theories, the elective mute's family is characterized by mother/child enmeshment, a peripheral and passive father, and the presence of one or more shy family members. The identified patient's symptoms are precipitated or exacerbated when a family with this structure is faced with the developmental task of allowing the child to move out of the home and attend school. This transition in the family life-cycle may be more disruptive if the family is physically, socially or culturally isolated, since the extrafamilial environment is viewed as threatening by the family as a whole. The core symptom of the identified patient may be seen as serving a variety of functions within the family. For example, it may allow the parents indirectly to express their aggression or anxiety about their isolated position within the community. Mutism may also indicate that the family have a secret which they do not wish to divulge, e.g. sexual abuse.

A variety of psychodynamic formulations have been suggested, many of which attribute a cardinal role to the elective mute's attempts to deal with aggressive impulses. For example, elective mutism has been interpreted as an inhibited or denied oral aggression, or anal retentiveness (i.e. a form of passive aggression) .

Hypotheses offered by behavioural theorists tend to focus on reinforcement contingencies which maintain the symptomatic mute

behaviour. For example, refusal to speak may lead to anxiety reduction in children who suffer from social anxiety. Where children have conduct disorders, elective mutism may be viewed as a strategy the child uses to manipulate the environment in a coercive fashion to obtain secondary gains.

### **TREATMENT AND PROGNOSIS**

The prognosis for elective mutes is poor. In a retrospective five- to ten-year follow-up study of treated cases, only 46% showed improvement (Kolvin and Fundudis, 1981). The condition has proven resistant to traditional individually oriented behavioural and psychodynamic interventions (Kratochwill et al., 1979). Direct attempts to coerce the child to speak are ineffective. A gradual and supported progression from non-verbal to verbal play characterizes most individually oriented treatments.

Of the systems-based behavioural interventions that have been developed, stimulus fading coupled with reinforcement is currently the most effective treatment for elective mutism (Sanok and Ascione, 1979; Cunningham et al., 1984). The term *stimulus fading* refers to the role of the child's mother and family on the one hand, and his teacher and school on the other as discriminative stimuli for mutism and speech, respectively. The child attends school with a member of the family to whom he or she will talk. Within the school (usually in an empty room), the child and family member talk together. By arrangement, the class teacher gradually approaches the child and family member as they converse. Once this has been achieved without the child becoming silent, the teacher begins to contribute to the conversation, and the family member reduces his or her participation. Peers may be introduced into the conversation group at this point. The family member then gradually withdraws from the school, and the conversation group is gradually moved into a normal classroom situation. Throughout the programme, the parent and teacher reinforce the child's successive approximations to normal conversational behaviour. A programme such as this is usually conducted over a number of sessions (ranging from twelve to 180), although one-day marathons have been reported (Reid et al., 1967).

There are few reports in the literature describing the progress of the concurrent family and individually based interventions with elective mutes (Rosenberg and Linbald, 1978). In the case described below, a family therapy format was used to implement a variant of the stimulus fading plus reinforcement programme. Concurrently, the child attended individual play therapy sessions in which successive approximations to normal play involving verbalization were rewarded and individuation was facilitated.

## **CASE EXAMPLE**

### **Background information.**

**The identified patient.** Jenny Conn, a six-and-a-half-year-old girl was referred to our clinic by her general practitioner. She had a four-year history of elective mutism, the onset of which coincided with the birth of her younger brother. Her refusal to speak was first noted at that time by the teachers at the playschool which she was attending and indeed, her mutism was confined to this playschool environment. At the age of three-and-a-half, she got lost in a large shopping centre in a neighbouring town, and since then had displayed a strong fear of being left alone with strangers, a reluctance to venture far from the house alone and a marked reduction in the number of people with whom she was willing to talk. At the age of five, she refused to talk to her next door neighbour after the neighbour gave birth to another child. When we first met the Conns, Jenny had been attending primary school for two years and had never spoken in that environment. On the child behaviour checklist (Achenbach and Edelbrock, 1983) which was completed by both parents, Jenny obtained an internalizing T score of 59 and an externalizing T score of 67. These psychometric results indicated that in addition to the central symptom of mutism, Jenny also displayed a large number of conduct problems (in comparison with age-matched peers). She had a history of nocturnal enuresis which was resolved without treatment when she was four years of age.

**The family.** The family comprised Mr and Mrs Conn (neither of whom had previously been married), Eileen (thirteen years), Jenny (six-and-a-half years) and John (five years). Neither parent had a psychiatric history, although both reported personal life events which had significance for Jenny's condition. Throughout Mr Conn's youth and until the early years of his married life, he had a fear of eating meals outside the home. To this day, he still gets *twinges* in his stomach when eating at a restaurant. He presented as a shy but congenial man in contrast to his outgoing and talkative wife. Mrs Conn had a history of miscarriages, one prior to Eileen's birth and another (involving twin girls) before Jenny was born.

There was no evidence of marital discord, problems with Jenny's siblings or significant grandparental involvement in the presenting problem. On the McMaster family assessment device (Miller et al., 1985), the parent's scores did not suggest the presence of serious family pathology. The family structure was clearly one of an enmeshed mother-daughter dyad with a less involved (though by no means peripheral) father.

**Social interaction surrounding the symptom.** Part of the

delay in the referral reaching our clinic may be attributed to two factors. First, the family and school waited a year for Jenny to grow out of her mutism before taking any action. Secondly, on her own initiative, Mrs Conn in conjunction with the teacher, devised and implemented a stimulus fading programme during Jenny's second year at school. At the stage where Jenny would read to her mother and the teacher at school in the same room, Mrs Conn (without Jenny's consent or knowledge) sneaked home. When Jenny noticed this, she clammed up again and suffered a complete relapse.

At the time of referral, Jenny's school, family and peer group had all accepted her elective mutism and developed ways of accommodating it. For example, her parents would tape-record her reading at home and bring this to school so that the school could provide Jenny with reading material to match her ability. Her peers at school would communicate with her in sign language or by passing notes.

**Hypothesis.** The following predisposing factors were identified as setting the scene for the development of Jenny's symptoms. First, because Mrs Conn had her second miscarriage before Jenny's birth, she welcomed Jenny (a child she thought she might never have) with great warmth and developed a deep and involved relationship with her. Second, because of his own difficulties about eating in public, Mr Conn was predisposed to be accommodating to similar symptoms such as elective mutism in his daughter. Third, Mr Conn provided his daughter with a model for *shy behaviour*. Fourth, Mr Conn's neurotic traits may have been inherited by his daughter.

The birth of a sibling and of a neighbour's child, the incident on the shopping trip and school entry were the main precipitating and exacerbating factors.

The symptom was maintained over time because it probably served a variety of functions for Jenny and her family. Initially, it may have been a way for Jenny to express anger at those who attempted to usurp her position as *the baby* of her social network (e.g. her playschool teachers and next door neighbour) without suffering reprisals. Following the shopping incident, it may have helped Jenny to reduce anxiety associated with separation and entry into new social situations. However, from the point of view of treatment planning we assumed that the central function of the symptom was to provide Mrs Conn with a way of legitimizing her overinvolved relationship with Jenny after the birth of her son.

The symptom was also maintained by the way in which the school had accommodated it. Initially, the school placed few demands for speech on Jenny because they believed that she would spontaneously recover. Later, they accepted the intractability of the

disorder when the mother's stimulus fading programme, which seemed eminently plausible, was ineffective. The school saw Jenny's mutism as an expression of illness rather than disobedience and their response was to socialize her into an invalid rôle.

### **FAMILY THERAPY**

**Session 1.** In an initial evaluation and contracting interview attended by the entire nuclear family and conducted by both of us, the background information (set out above) was obtained and the hypothesis drawn up. We thought that a treatment programme aimed directly at symptom removal would be met with little resistance, provided a way could be found to allow Mrs Conn to channel into it her high level of concern for her daughter (Alexander and Parsons, 1982). However, the programme would also have to provide Jenny and her mother with legitimate opportunities for separation. Our overriding treatment strategy was to offer Mrs Conn a chance to successfully rerun her stimulus fading programme (with back-up from us), but to ensure that concurrently Jenny attended play therapy sessions without her mother.

After the break, during which the hypothesis and treatment plan were developed, we told the family that we were impressed by the severity and duration of the symptoms. Mother and father looked relieved at this statement. We said that we wondered what would have happened if Mrs Conn's programme had been carried out more slowly, and the parents replied that it probably would have worked. We acknowledged this and offered to help Mr and Mrs Conn plan such a programme in a slow and careful manner over four sessions. The family accepted this treatment offer. We said that only the parents need attend these meetings.

We then pointed out that unless we had a fair understanding of Jenny herself, and her view of the world, we would have no basis for developing alternative solutions if the stimulus fading programme failed. The parents agreed with this wholeheartedly. Individual play therapy sessions for Jenny (with S.A.) were then suggested as a way of achieving this goal. With some anxiety, the family agreed to this. S.A. said that she would also attend the family therapy sessions and feedback in broad terms useful information arising from the individual sessions, but she emphasized that the blow-by-blow details of these meetings would remain a confidential matter between Jenny and herself.

The parents consented to having the play therapy sessions videotaped. Data sampled from these videos and the details of the individual sessions are described in later sections of this paper.

**Session 2.** The second family session was held after a three-week interval. Jenny had just completed her first two play therapy

sessions that week. The parents mentioned that Jenny was frightened to attend the sessions and that she had fantasized that S.A. might harm her in some way. During the three-week interval, Jenny had been even more withdrawn at school. Mrs Conn had taken a job as lunch time assistant at the school and was spending her morning in Jenny's classroom working informally as a teacher's aid. Our instinct was to confront Mrs Conn's further overinvolvement with Jenny, but in keeping with our view that this would elicit resistance we informed Mrs Conn that we fully approved of her decision and that her special role within the school would be valuable in solving her daughter's problem. In keeping with the contract, we devoted the session to planning a stimulus fading programme. The final version of the programme contained the following elements.

- (1) In Jenny's presence, the parents were to avoid attributing Jenny's mutism to fear or malice. Rather, they were to attribute it to a lack of readiness. For example, they should avoid saying *Jenny doesn't speak because she's scared* or *She doesn't speak to get special attention, the little brat*. Rather, they should say *She is not ready to speak at school yet*.
- (2) Mrs Conn was to describe the stimulus fading plus reinforcement procedures (set out in points (3) and (4) below ) to Jenny as the best way to help her. Mrs Conn was to decline to help her daughter until she clearly indicated that she was ready. The failure of Mrs Conn's previous attempt to help her daughter using a stimulus programme was to be highlighted to Jenny by her mother as the main danger of starting the programme before Jenny was ready.
- (3) Mrs Conn was to arrange a series of stimulus fading sessions with the school teacher in which Jenny was to read, while the distance between herself and her mother was increased, and that between herself and the teacher was decreased. The steps in the programme were to be decided by Mrs Conn, but Jenny was to be given control over when they occurred and the speed of the overall programme.
- (4) Mr Conn was to set up a star chart reinforcement programme at home. Each day Jenny spoke at school she was to receive a star from her father when he came in from work in the evening, and five stars (even if they were not consecutive) could be cashed in for a treat. Mr Conn was encouraged to draw up a reinforcement menu of treats for Jenny with her help.

In developing this programme, the parents were encouraged to outline the best they could come up with. We then offered broad modifications, e.g. points (1), (2) and (4), and encouraged them to operationalize these. A participative rather than prescriptive approach to programme construction was used so that the family could ultimately take responsibility for Jenny *cure*, should the programme be successful. The

proposed programme provided and opportunity for Mrs Conn to constructively channel her overinvolvement, without excluding her husband.

**Session 3.** An interval of two weeks elapsed between this and the preceding session. Jenny had attended five individual sessions in all at this point, but she had screamed throughout each of them. The parents had outlined the programme to Jenny with one modification. Mrs Conn had told Jenny that she could earn stars by both speaking within the context of a stimulus fading procedure at school and by not screaming at the clinic when she attended individual sessions.

On the day following this, Jenny spontaneously whispered to her mother in school and obtained a star. The next day, the teacher directly asked Jenny to read (outside the context of the agreed stimulus fading programme) but Jenny was unable to do so. Mrs Conn told Jenny's teacher and the class that she could not read aloud yet because she was not ready. Mrs Conn admitted that this reframing took considerable pressure off both herself and Jenny.

Because of the constant screaming during the individual sessions, S.A. invited Mrs Conn to participate in session 5 and to note its effect on Jenny's behaviour within the play therapy situation (see below). The day following this session, Mrs Conn was playing a game of *I spy* with the children at school and asked the children what they could spy beginning with *M*. Jenny said *Mum*. All Jenny's classmates responded to this, her first word in school, by engaging her in conversation, to such a degree that Mrs Conn had to ask them to stop. Jenny still did not converse with the teacher. That night, while Jenny was being bathed by her mother, she said, *The old Jenny has gone away now and good riddance to her. The new Jenny is going to speak to everyone at school.* Jenny then asked if she had to continue coming to individual sessions at the clinic, which her mother took to mean that she wanted to terminate individual treatment. The next day, Jenny spoke to the next door neighbour, with whom she had not conversed since the birth of her baby a few months previously.

In keeping with their previous attempt to solve the problem, the parents were showing evidence of wanting to rush the treatment process. Mrs Conn had stuck to points (1), (2) and (4) of the agreed programme, but had decided of her own accord to change the stimulus fading element once Jenny showed signs of spontaneous speech in school. She also wanted to stop the individual sessions.

The interventions described below may appear paradoxical. In fact, they were intended to be straightforward directives aimed at slowing up the process of problem-solving so as to avoid mistakes. We took such an approach because the Conns were a family who rushed at problem-solving but accommodated well to a directive therapeutic style

(de Shazer, 1982).

- (1) We expressed concern at the speed of Jenny's improvement and advised that the family prepare itself for a relapse. We pointed to the dangers of demoralization which can result from falsely based optimism. We described in detail a number of families with whom we had worked and highlighted the pattern of gains and setbacks which symptoms and habits follow before a long-lasting change can be reached.
- (2) When Jenny relapsed in school, we advised Mrs Conn to tell the other children that she needed a rest because she was not used to talking a lot and had become exhausted.
- (3) We highlighted the importance of the individual session as a format that could be used for understanding Jenny herself, and that such an understanding would be crucial to the correct management of relapses.
- (4) We advised Mrs Conn to have a dialogue with the teacher in Jenny's presence about the importance of not requiring Jenny to do oral classwork until she was ready. We said that a reinforcement menu, separate from that used at home, should also be discussed and drawn up in Jenny's presence.

**Session 4.** This session occurred a week after session 3. The family took on board our views concerning relapses and completed the tasks we set them in the previous session. Mrs Conn never formally constructed and executed the stimulus fading procedure as planned. Rather, she followed Jenny's lead by rewarding her for spontaneous speaking in school, and Jenny spontaneously enlarged the number and type of people with whom she talked and the distance that her mother was from her while this occurred. At this point, she was talking to all the members of her class and to teachers in the school. The school said that her speech could best be described as baby talk. Jenny had participated in a school play, albeit in a non-speaking part, and had gone horse riding for the first time. Mrs Conn had reduced the time she spent in Jenny's class to thirty minutes per day. We congratulated the family on their excellent progress and gave them full credit for the gains made.

Jenny continued to attend individual play therapy sessions, had stopped screaming in them and had progressed from non verbal to verbal play. Her mother continued to express anxiety about the necessity for Jenny's attendance at the individual sessions and would frequently try to spend time with S.A. before and after these meetings discussing her concerns about Jenny.

We closed the session by framing Jenny's reluctance to speak as a way of slowing down the process of separating out from the nuclear family and growing up. The parents spontaneously added that her

conduct problems, which were now resolving, were really immature behaviour. We took this to indicate that the family accepted our reframing of Jenny's symptoms. In the light of this reframing, Jenny's attendance at the individual sessions was described as a forum within which Jenny could learn to be comfortable with an adult outside the bounds of her nuclear family. We acknowledged that Mrs Conn's unscheduled conversations with S.A. were an expression of her wish to help us understand her daughter. S.A. confessed that she often forgot some of what Mrs Conn said and would prefer if she kept her observations in a diary and brought them to future family therapy sessions for review. We also pointed out that the urgency with which she typically gave these to S.A. before and after the individual sessions might give Jenny the erroneous idea that her mother did not view the play therapy sessions as safe. Mrs Conn confessed that she talked to S.A. to reduce her own anxiety and said that she would try to use a diary as suggested for this purpose instead. We agreed to meet two months later.

**Session 5.** The parents reported that Jenny was now speaking fluently in all social situations. Her conduct problems had also reduced markedly. Jenny continued to go horse riding and had begun swimming. Mrs Conn had withdrawn from Jenny's class completely. Credit for change was once again given to the family.

The parents noted that Jenny still showed a fear of tackling new and challenging situations. S.A. confirmed that this had also been observed in individual sessions.

We put it to the family that this situation might resolve spontaneously but that Jenny's social development could be facilitated by her continued attendance for individual therapy. We referred to Mrs Conn's admission to experiencing anxiety when her daughter was separated from her and offered her an opportunity for individual therapy with another therapist to deal with this issue. The family accepted the offers of individual therapy for Jenny, individual work for Mrs Conn and attendance at a follow up appointment in three months.

**Session 6.** The parents reported that Jenny's progress had continued. She was no longer electively mute. Her T score on the internalizing scale of the child behaviour check list had dropped from 59 to 45. On the externalizing scale, her T score was now 58, whereas it had been 67. These changes reflected the clinically significant improvement which Jenny displayed. Jenny was now attending swimming, horse riding and had just been sworn in to the Brownies that week in front of a large group of children and parents! This was her crowning glory.

At the contracting interview with the individual therapist Mrs Conn decided not to pursue the individual therapy option for herself and

also decided it was time for Jenny to terminate individual therapy. The parents said that Jenny found conversation intrinsically reinforcing and that her self-confidence would improve as her speech allowed her to make more and better friendships. Seeing this happen, Mrs Conn said, would lessen her own anxiety about Jenny's well-being. Mr Conn acknowledged that when Jenny changed class, she might relapse. He said that he thought they could probably handle such relapses, but would contact us if they met with difficulties beyond their competence. In a telephone conversation five months after this final session, Mrs Conn reported that the gains Jenny made had been maintained.

#### **INDIVIDUAL CHILD-CENTRED THERAPY**

These sessions took place in a well-equipped play room. They were spaced between three and ten days apart, with the exception of a three-week break at Christmas.

**Sessions 1-4.** Throughout these sessions which comprised the first stage of the individual work, Jenny displayed a high level of anxiety and did not speak. In sessions 1 and 2, she would stand next to the door rigid with her hands in her pockets or over her mouth and scream. In sessions 3 and 4, she drew a series of pictures of people. Initially, her productions were age-appropriate, but as she progressed through the sequence, the figures became more distorted and features were added (e.g. a face with three eyes) or omitted (e.g. a body without a head). In these sessions, she also drew a series of repetitious simple patterns. Her art work was quite messy and her behaviour during it was clumsy.

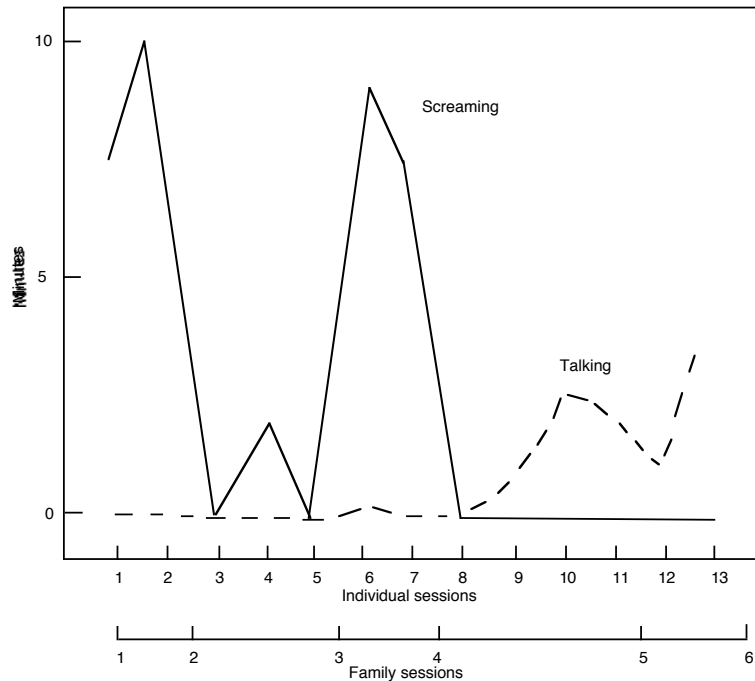
The main therapeutic intervention during these sessions was to acknowledge Jenny's distress, but to communicate that the play therapy room was a safe place (Axline, 1947).

**Sessions 5-8.** Because of the level of anxiety displayed by Jenny during the preceding sessions, her mother was invited to session 5 to reassure Jenny. The session also provided a forum within which to directly observe mother-daughter interaction.

S.A. asked Mrs Conn and Jenny to play together while she observed. The overriding conclusion afforded by this exercise was that Mrs Conn typically treats Jenny as if she were a two-year-old. Mrs Conn initiated and led the play rather than following; she stayed overly close to Jenny; she overpraised accomplishments and frequently spoke for Jenny. On the positive side, the deep affection between Jenny and her mum was clearly obvious in the session.

Over the next three sessions, Jenny displayed decreasing levels of anxiety and anger at her mother's absence from the play room. Her tearfulness diminished.

**Figure 6.1. Time spent talking and screaming over the course of treatment**



At the end of session 6, she spoke her first word in individual therapy, *Mummy*. (It is noteworthy that this was the first word she spoke aloud within the school context on the following day (see family session 3).) By session 8, she was speaking a few sentences within each therapy period. She began to ask S.A. for things to play with but made no attempt to involve her in her games. At this stage, Jenny also became more mobile and exploratory.

In addition to reflection and reassurance, reinforcement for all vocalization approximating speech, and for all self-initiated constructive play activities, was the main therapeutic intervention during this phase of therapy (Ross, 1974).

**Sessions 9-13.** In the final five sessions, Jenny conversed more and more freely with S.A. Her grammar and pronunciation were age-appropriate, but the intonation she used was immature, so that her speech sounded like baby talk. Her exploratory behaviour expanded and she was able to walk about in the clinic corridors, although she was clearly afraid of strangers. Her clumsiness did not improve. Jenny's play

was confined to drawing, painting and on one occasion she made some snowmen outside. She never initiated imaginative play involving role-playing with S.A. or dolls and puppets, although such toys were quite readily accessible to her within the play room. She was reluctant to try out unfamiliar activities. She showed little curiosity about the therapist herself and did not display any evidence that she had developed an attachment to her.

Three significant aspects of Jenny's world view were identified during this phase of therapy. First, she believed that her mother really wanted her to stay mute so that she could come to school and speak for her. Second, Jenny saw herself as inadequate and incompetent, and it was these beliefs that prevented her from engaging in challenging and unfamiliar activities. She said that she had developed this belief by observing her mother's reactions to her. Third, she was unable to recognize and distinguish the feelings of sadness and anger in herself and others, although she could identify happiness and fear.

Throughout this phase, a non-directive and reflective therapeutic style was used. Structured social reinforcement for speech was no longer used.

The amount of time Jenny spent (a) screaming and (b) talking was measured for the last ten minute segment of each videotaped play therapy session. These behavioural data are presented in Figure 6.1 to illustrate quantitatively the change in Jenny's symptoms over the course of therapy.

## **DISCUSSION**

This case illustrates the way in which individual and family based treatment *tactics* may be effectively integrated into a unified treatment plan guided by a systemic hypothesis.

In retrospect, we have conceptualized the therapy in the following way. First, we developed a trusting relationship with the family to reduce their resistance to directive treatment by being non-blaming and by acknowledging the legitimacy of the mother's overinvolvement. Second, we defined the problem as difficult and only possibly solvable so that (a) they would agree to let Jenny attend individual sessions; (b) they would not try to rush for a solution and so exacerbate the problem as they had done in the past; (c) they would not feel that they were inadequate for failing to solve the problem previously; and (d) they would not be demoralized if no change occurred early on in the programme. Third, we reframed the problem in developmental terms and gave the parents a solution (stimulus fading and reinforcement) to explain to their daughter. When Mrs Conn told Jenny the plan, she probably communicated to her daughter that she no longer needed Jenny to behave in an immature way. Then, suddenly

rather than gradually Jenny began to speak in school. This pattern of change suggests that the initiation of a behavioural stimulus fading programme led to a change in Jenny's perception of her relationship with her mother. An explanation based on classical conditioning would seem inadequate here. Fourth, the first four individual play therapy sessions amounted to a flooding procedure where both Jenny and her mother were exposed for long durations to the feared stimulus of separation, and ultimately this led to some reduction in their anxiety levels. Fifth, during the second phase of play therapy, both within these sessions and at school, Jenny received social reinforcement for speech. It was not long before she learned that speech is intrinsically rewarding and so a self-reinforcing cycle developed. Sixth, during the third phase of individual therapy core elements of Jenny's world view were disclosed and a focus for longer-term individual work identified. At the same time, Mrs Conn recognized that personal issues which fuelled her overinvolvement with Jenny might need to be addressed. However, in the light of Jenny's symptomatic improvement on the one hand, and Mrs Conn's view of individual therapy as threatening on the other, she ultimately declined offers of individual therapy for Jenny and herself.

Compared with cases reported in the literature, ours was a particularly severe one, given that the mutism formed part of a constellation of behavioural problems which had persisted for four years. Eighteen sessions conducted over a period of seven months were necessary to treat this case, and substantial symptomatic improvement occurred after seven of these. These observations suggest that concurrent individual and family therapy is a powerful brief treatment modality for this disorder, deserving controlled evaluation.

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