

Elective Mutism in Childhood*

GILBERT SILVERMAN AND DOUGLAS F. POWERS

*Division of Child Psychiatry,
Medical College of Virginia,
Richmond, 23219*

Introduction

Elective mutism was first described in the literature in 1877 by Kussmaul who used the term "aphasia voluntaria" in order to describe children who, though not severely disturbed, are willfully mute for purposes they refuse to disclose. From this time until the 1930's there was very little else in the German literature. In 1934, Tramer coined the name "elective mutism" which has gained a world wide acceptance. More recently in the German literature there have been papers by vonMisch (1952) Spieler (1944) and Weber (1950). Spieler, in his review of 50 cases of elective mutism, came to the conclusion that a "neurotic personality" was the outstanding feature in the mute children. In 1945, Tramer interpreted the behavior as "an archaic defense reflex retained for an abnormally long time." Weber's four cases were compared by vonMisch in his paper in which vonMisch also had a number of observations. They were: 1) environmental factors may precipitate mutism; 2) mutism often occurred upon the child's separation from the family, especially at the time of his entry into school; 3) while possibly hereditary and intelligence factors might play some part, the disorder was basically psychogenic; 4) all cases demonstrated excessive ties to mother; and 5) the selection of mutism is a symptom with possible relation to traumatic experience at the time when the child was developing speech. Galzmann, a Swiss pediatrician, also described the "anal sulker syndrome," the three main symptoms being: 1) mutism, 2) urinary retention, and 3) voluntary retention of stools.

The first major report in the English language literature was made by J. D. Salfeld in 1950. He reported the following observations: 1) the onset of elective mutism occurs between 3 and 5 years of age; 2) there is no mental defect; 3) there frequently seems

to be a familial factor; 4) there is a relatively great resistance to treatment; and 5) there may be early somatic psychological or compound traumata. Adams and Glasner, (1954) emphasized that the children in their cases came from severely disturbed home situations, were unable to develop trust in their parents, were slow in toilet training, and despite the ability to hear and understand the spoken word, used pantomime and peculiar sign language to communicate. In a paper in 1963 Browne and associates reported that these children appeared to be either fixated or regressed at the anal stage of development. Their manifest behavior in many ways reminds one of a child of two years who cannot speak to people other than those with whom he is familiar. They utilize muteness as a weapon to punish people who have offended them. There appears to be a neurotic split in the family with the mute child identifying with one of the parents in an ambivalent symbiotic relationship. Pustrom and Speers (1964) felt that elective mutism was but "one of several manifestations of the neurotic disorder found in these children" which includes school phobia, enuresis, food conflicts, preoccupation with cleanliness, obsessive compulsive attributes, problems in self-identity, withdrawal and depression. The common factors in these cases that they reported concerned conflicts regarding mutual dependency and revealing family secrets with fear of retaliation from parents. The most recent report in the literature was that of Wright (1968), but unfortunately this article only dealt with children who would not speak in school and the usual diagnostic criteria for elective mutism were not followed.

Over the years many children have been referred to the Virginia Treatment Center for Children in Richmond with the symptom of mutism. The mutism fell into a number of diagnostic categories—schizophrenia, hysterical aphonia, brain damage, degenerative brain diseases, and elective mutism. Our experience with five children with elective mutism is as large a sample as can be found in the American literature. As criteria for the diagnosis of elective mutism

* Presented at the Eighth Annual Spring Forum for Child Psychiatry, May 29, 1970, sponsored by the Virginia Treatment Center for Children and the Division of Child Psychiatry of the Medical College of Virginia.

the following were used: 1) The children would speak only to the immediate family and close friends and would not speak to strangers or in school. 2) The symptom was not a transitory one and had to exist for a period of at least two years. 3) The symptom would not yield to the usual blandishments that one would use to entreat a child to speak. 4) No severe underlying psychopathology or demonstrable organic disorder could be present. 5) The children must at least be functioning in the average range of intelligence.

Case Summary—*Eric*

Eric, a thirteen year old boy, was referred to us in 1963 by the Juvenile Court at the suggestion of a local mental health clinic. History at the time of the evaluation was that Eric had not spoken to any adults for seven years and had not spoken to his parents for five years. The only communication he had had was with his siblings. The cessation of his speaking had to do with his being hospitalized for abdominal pain. Previous to this he was supposedly a happy, affectionate, talkative youngster who seemed to get along well with other children and members of his family. Very interestingly the symptom came to be referred to us not at the request of the family or parents but when this rather unusual symptomatology was noted by the personnel of the Juvenile Court.

The patient was the fifth of eight children in a very chaotic family. The father, a career Army man spent little time at home and the mother was a rather inarticulate depressed lady who has very little in the way of internal resources. Even as the therapy evolved with the patient she was, for the most part, still unable to gain any insight or to work at all on her difficulties in relation to her son. There was no contact with the father during treatment.

When Eric was initially seen, he was felt to be an extremely angry boy who seemed quite angry with the world in general and toward adults in particular. He seemed to feel, partially because of his small size, that he was inadequate, unable to compete with peers, in danger of being injured and in general, small, helpless and infantile. Although testing was then incomplete because of his unwillingness to talk, he was thought to be of average intelligence. It was also felt that there was some degree of anxiety and depression in this boy.

It was recommended that this boy enter in-patient treatment and he was hospitalized in September of 1963 and discharged in June of 1964. It was felt at the time of admission that Eric could certainly utilize the hospital situation as a place where he could rebuild his life, and it was hoped that at the time of discharge he would not go home, but would be placed in a foster home. It was felt that the Treatment Center could offer him a safe haven which was some-

thing he had never really experienced during his entire existence. It was felt that in view of this he would be able to learn to trust people once again and begin to talk. The improvement in the hospital was a gradual one. At first he was quite negativistic, withdrawn and would not relate even with his peers. Gradually, his peer relationships improved and he began to communicate with his therapist by notes. Gradually the notes disappeared and he began to whisper into a dictating machine when the therapist was out of the room. As time passed communication was carried on by telephone with the boy being in one office and his therapist in the other. This then went to the therapist sitting in one room with the boy in another with the door slightly ajar. Finally, after many months he was talking directly with the therapist and at this time he began to talk to other staff members in the Center.

As the material unfolded it became quite obvious that this boy had had much deprivation and conflict. He talked of the extreme deprivation in terms of food, warmth, and of tremendous angry feelings toward his father who would abandon the family with great regularity. He related that the family situation was oppressive, and that he was constantly told to "shut-up." One day he finally decided it would be the safest thing to do. He said that when he talked, "it got me in trouble" and he decided to stay silent which he had done for about seven years. With the advent of his talking, there was a great improvement in this boy and he showed across the board improvement in everything from school work to athletics.

At the termination of treatment, this boy had been placed outside of his home with an aunt and uncle and had resumed speaking.

Case Summary—*Dan*

This thirteen year old boy was referred to the Treatment Center in May of 1965 with an extremely interesting history. After a normal birth and development this child did well until age 2½ when his father left the home and the family situation deteriorated. This caused marked alterations in Dan's behavior and he gradually became more withdrawn and mute. His mother also became extremely withdrawn and depressed at this time. At age six years he was not able to enter school because of his withdrawn, unhappy state. At age seven he entered school and completed the school work although he still was not able to talk. In April of 1959 when Dan was seven, he was seen in the psychiatric clinic at the Medical College of Virginia. He also was seen at a guidance clinic for a brief period of time and finally was hospitalized at a State Hospital from June, 1960 until August of 1963 and was said to have improved. A great deal of this withdrawn behavior disappeared and he was able to complete significant classwork without talking. After

his return home, he again went to his local school and did not talk but was able to keep up academically. In January of 1965, Dan sustained an eye injury and was hospitalized at M.C.V. Once again the issue of the elective mutism was brought up and ultimately he came to the Treatment Center for evaluation and admission. He was hospitalized from August of 1965 to October of 1965 and then followed as an out-patient until June of 1966. During this time in the hospital he could not relate very well to other children and again was unable to deal with the speech problem. His mother was a rather helpless individual who did not seem to be able to help him with his problem.

Following his hospitalization and out-patient care, he was lost briefly to follow-up, but approximately six months later we received a report that he had had a confrontation with the police after allegedly stealing a car. When threatened by a policeman that if he did not talk he would be taken to jail, Dan immediately began talking and since then has had no further difficulties with elective mutism.

Case Summary—*Sarah*

This child was first seen by us in January of 1967 with a history that at age three or four she had not spoken to people outside of the home. The child had been seen in a variety of settings including school and a local guidance clinic but without success. Because of the prolongation of the symptoms over a period of some three to four years she was finally referred to the Treatment Center for an evaluation and treatment.

The patient was the first child born of her mother and father who were ages 26 and 25 respectively. The father appeared to be a rather mature, well put together individual but the mother at the time of the evaluation was thought to be grossly disturbed having a great deal of paranoid thinking. There was a tremendous amount of marital discord in this family. The parents presented a history of early feeding difficulties with mother unwilling to continue breast feeding the child and a great deal of difficulty in toilet training which was accomplished both day and night at age twenty months. When Sarah was three years old, a sibling was born and a great deal of sibling rivalry came to the surface. A half a year later the mother decided to go back to work for "her mental health," and Sarah was left with a neighbor. At this point her well developed speech pattern in terms of social interaction stopped. In the ensuing four years she was, at first, a very withdrawn, sullen child who would not talk, and then later became an extremely aggressive, rageful, destructive child who would talk to no one except her immediate family. In the public school situation she could not handle her relationship

with other children very well and tended to be a loner and was quite isolated.

She was ultimately hospitalized at the Treatment Center in September of 1967. At the time of admission it was noted by the child's therapist that the parents seemed quite pleased in some ways about the controlling behavior of their daughter and how successful it had been.

Once in the hospital it was noted that Sarah used some of the children to do her talking for her much as she had used her brother. This interaction with peers excluding adults appeared to mirror the relationship she had had at home. When it became apparent to her that the staff would not behave as outsiders had and allow her to use other people to communicate for her and/or use signals instead of words, she became quite rageful. She went through a prolonged period of destructive behavior with extremely regressed parts such as urinating on the floor. Gradually this abated and the child moved into some significant and hopefully corrective relationships with people. As the year of residence drew to an end there was again a great deal of difficulty with the parents, and the child, in spite of the gains that she had made, had begun to exhibit once more a great deal of regressive behavior with a marked decline in her verbalizations.

After she was discharged the parents made it quite plain despite multiple contacts by our agency that they did not wish to have anything further to do with the Treatment Center. There was contact with a psychiatrist who informed us that the family had undergone further upheaval and that once again Sarah was having difficulty in talking to people outside of the home.

Case Summary—*Becky*

This seven year old child was first seen by us in June of 1967 with a history of not having talked for a period of at least two years. This child, a ward of the Public Welfare Department, had come into their charge some two years before with a history of severe deprivation and an extremely chaotic family existence. At that time, she was not talking and the history was unavailable as to how long her problem has existed. It is known that in her past history there were multiple separations and other such difficulties.

Once in the hospital situation Becky slowly, but surely, began to form relationships with various people. Her obvious deprivation and lack of somebody to relate to became manifested in her clinging to any person who came along. Finally she began to start developing some reasonable peer relationships and gradually began to enter into the program. After a period of time it was noticed that she did begin to relate, by whispering, to the other children. This gradually spread from whispering to the children, to

the staff, and then to her therapist. It was obvious that this child was quite mistrustful and her non-talking was a way of not getting emotionally involved with people. It was also increasingly evident that once she had felt some security in her relationship to people and could honestly begin to believe that the staff of the Treatment Center were there to help her and not to deprive her further, she began to start with verbal behavior.

As part of the overall treatment program, we felt that it was necessary for her to have a stable home situation. Finally a family was located and she managed to relate quite well to them. After a series of visits with these people, she was ultimately discharged from in-patient care to the family. Later reports indicated that she was developing quite well in her relationships with the family and in her abilities to verbalize.

Case Summary—*Charles*

Charles, who is age twelve, was originally referred to the Treatment Center field-unit in 1967 by a County Health Department. Evaluation revealed that he had not spoken publically for the past three years. It would seem that his symptom began one day in the first grade when he was allegedly told to sit down and shut up. Immediately following this, Charles defecated in his pants and was told to stand outside for the rest of the day. After this incident, he refused to talk publically to any peers or adults. Up until his admission he had only continued to converse with his siblings and his parents.

The family constellation is an unusual one. His father is an extremely damaged individual who is suffering from a chronic mental illness and has had emotional problems since World War II. He has made numerous trips to the Veteran's Administration Hospital and receives a service connection pension for his disability. Charles' mother is a rather old looking, care-worn lady who runs the household. She is intimately involved with the children and extremely overprotective. She is not an unintelligent lady and has been aware for some time of her son's troubles, but until the present has been unable to divorce herself sufficiently from them to bring him into treatment. Charles has a half-sister age 14, by the mother's first marriage (which ended with her husband dying) and a younger brother, age 9. Neither of these two children has any overt emotional problems.

Over the years intense pressure has been applied to this family by various sources in order to gain some treatment for Charles. In February of 1968, he was removed from his home by the Court and placed with an uncle and aunt where he underwent the remarkable process of socialization. The aunt writes in her letter that he could not use eating utensils, did not have very much in the way of schooling and

etiquette, and had only the most primitive concept of the use of bathroom facilities. During this time, he showed remarkable improvement in his behavior, became much better socialized, developed manners, began to be much more self-sufficient but in spite of all this, Charles still did not talk. Because of the pressure that the parents put on the Court, he was finally allowed to return to his home although he was still legally a ward of the Welfare Department. Local out-patient psychiatric treatment was attempted for a period of time but without success.

The parents decided to seek evaluation in December of 1969. The diagnostic was a rather unusual one and consisted of talking with the parents and taking them on a tour of the Treatment Center. The parents had finally come to the realization that their son would indeed need some help in coping with the world and that they would not be around to do this for him. Their greatest fear became verbalized during the diagnostic. Would Charles be treated in the same manner as his father had been treated in a large mental hospital? At the time both of the parents were quite surprised about the program we had at the Treatment Center and this has been borne out in repeated conversations with them.

Charles' isolation from his peers is in many ways similar to his family's isolation in a social world. These people live in a fairly inaccessible part of a scarcely populated county. They have little contact with outsiders except for some extended family in the area. They are terribly unsophisticated people and are quite frightened of authority figures, and outsiders.

Once he was admitted to the Treatment Center there was a great deal of initial difficulty encountered. He had no means of communicating except with hand gestures and when nobody understood this he would immediately break down and cry. It was felt that the first thing that should be done in terms of dealing with his non-verbal behavior would be to have him stop the gesturing and begin to at least use words if not in a verbal way, non-verbally. In order to do this we began by telling all persons coming in contact with Charles not to respond in any way to his non-verbal communications. We then gave him a deck of cards with careful instructions on how to use them. Various words were on them such as yes, no, snack, bathroom, school, food, etc. He began to use these cards, and for this began to receive the usual rewards. This was accomplished by a great deal of frustrated crying and rage, but he finally was able to accept the use of the cards and to make his way into the social life of the unit with them. As we moved from this to the next step, we began taking away various cards from him and replacing these by having him mouth the word which was on the card such as snacks, bedtime, courtyard, etc. This worked to the

ELECTIVE MUTISM

point that he was finally able to give up all the cards and could mouth anything to anybody on request. The greatest hurdle was getting him to use sounds. It was important, it was felt, to find the adequate reward to help him give up his behavior. Finally it was discovered that Charles had a tremendous propensity for fossilized shark's teeth and he was given the opportunity to earn some of these shark's teeth by making sounds. This proved most successful, and he then began to start making sounds which gradually evolved into words. He has moved steadily along into social interaction within the hospital. At the present time, Charles is now conversing with peers and talking in sentences to adults within the Treatment Center. He has also begun to speak with some of his extended family who have visited with him with great regularity. It is felt that further cooperation with his school is necessary to help handle him once he is at home.

Discussion

All of the five children that have been seen throughout the years at the Treatment Center have come from disturbed home environments. In four of the five cases (Eric, Dan, Sarah and Charles) one of the parents was grossly disturbed and in the fifth case (Becky), although the family was never seen, the referring agency thought both of the parents were disturbed. There appeared to be a marked disturbance in the parent-child relationships in each of these families which, it was felt, was directly related to the degree of family disorganization and psychopathology present in the parental figures. It was felt that this was etiologic in the onset of the mutism which occurred concomitant with some degree of separation from the parental figure. In Eric's case this was a hospitalization at age five; in Dan's case this was intermittently related to the father abandoning the family and the mother becoming depressed and withdrawn. In the case of Sarah, this occurred by the mother's returning to work; while in Becky's case, the abandonment of this child occurred by her family. Finally, Charles' problem developed by the separation of going to school.

Formulation

From the literature it would seem that the various people observing and reporting elective mutism seem to be split dynamically into two groups. The first group consisting of vonMisch, Salfield, Adams and Glasner, take the view that the primary difficulty appears in the oral stage of psychosexual development and is intermittently related to difficulties in object relationships. The other group of Glanemann, Brown and Pustrom and Speers, espoused the view that the root of the psychopathology is in the anal stage.

It is our considered opinion that although much of

the surface behavior appears to have to do with anal level difficulties characterized by compulsive withholding with a need to control the environment, the children we have seen have primary difficulties in the oral stage of development. These children suffer from an impoverishment of object relationships; they cannot tolerate separation, and they do not relate because of the fear of rejection. It is also felt that these children are quite empty and their ability to give is markedly limited. This view is not dissimilar to many of the ideas espoused by Ericson about the oral retentive phase of psychosexual development. It is felt that these children in part are arrested at this particular phase; and the treatment is necessary to help them move beyond this area of fixation.

Summary

Five cases of elective mutism seen in the Treatment Center over the past eight years have been reported. Fairly strict diagnostic criteria have been laid down and a comparison of the cases in the literature has been done.

References

- Adams M, Glasner J:** Emotional involvements in some forms of mutism. *J Speech Hearing Dis* 19: 56-60, 1954
- Browne E, Wilson V, Laybourne PC:** Diagnosis and treatment of elective mutism in children. *J Amer Acad Child Psychiat* 2: 605, 1963
- Ericson EH:** *Childhood and Society*. 2nd Ed. Norton, 1963, pp 72-75
- Pustrom E, Speers RW:** Elective mutism in children. *J Amer Acad Child Psychiat* 3: 287, 1964
- Salfield DJ:** Observations on elective mutism in children. *J Mental Science* 96: 1024, 1950
- Spieler J:** *Schweigende und sprachscheue kinder*. Olten, Switzerland, Otto Walter, 1944
- Tramer M:** Elektiver mutismus im kindersalter. *Z Kinderpsychiat* 19: 49, 1952
- Weber A:** Zum elektiver mutismus der kinder. *Z Kinderpsychiat* 17: 1, 1950
- Wright HL:** A clinical study of children who refuse to talk in school. *J Amer Acad Child Psychiat* 7: 603, 1968