

76. Communicative Behavior with Neurotic Developmental Disorders: Elective Mutism

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1. Introduction

There are two forms of psychological mutism — traumatic and elective; both are dramatic and both are rare. The main theme of this paper is an account of elective mutism.

The rarity of mutism may be the reason for the lack of a substantial literature on the subject of elective mutism. Following the original classic article by Tramer (1934), over the next half century there were only about half a dozen major contributions to the literature on this subject, culminating in the article by Kolvin/Fundudis (1981). And in the recent years there has been only one further research report of a controlled study with more than 20 electively mute children (Wilkins 1985).

2. Traumatic Mutism

This has an acute onset following a psychological or physical shock or injury. Some consider it to be an hysterical phenomenon as it is not associated with any disorder of the structures subserving speech functioning (lips, tongue, palate or vocal cords) and, furthermore, the patient is able to cough normally. The literature suggests that it is common, but a wide clinical survey has attested to its considerable rarity (Kolvin/Fundudis 1981).

3. Elective Mutism

This is the term coined by Tramer (1934) to describe a fascinating group of children, whose talking is confined to familiar situations, usually the home, and to a small group of intimates. It needs to be distinguished from the inordinate shyness that occurs relatively frequently in reception classes in school (Brown/Loyd 1975; Wright 1968), by its severity and persistence.

The literature suggests that the earliest manifestations are in the pre-school years, with the parents being unaware of significant abnormality because there has been a period

of relatively normal speech development (Eison/Pearson/Jones et al. 1965; Reed 1963; Salfeld 1950). Kolvin/Fundudis (1981) report that commonly an inordinate degree of shyness was present from the early years of life in the majority of cases and only in a small percentage were there indications that it had emerged for the first time at a later stage in development.

3.1. Epidemiology

From their epidemiological study, Fundudis/Kolvin/Garside (1979, 15) report a rate of 0.4 per thousand children in a total city cohort of 3,300 seven-year-olds. To put this in perspective, this is less common than broadly defined autism by a factor of two. Subsequently, the same team (Kolvin/Fundudis 1981) identified 24 electively mute children, over a period of six years, gathered from a wide survey of clinical departments of speech pathology and child psychiatry serving a large population in the North East of England. However, other workers have reported on larger samples of clinically or epidemiologically identified elective mute children. For instance, Brown/Lloyd (1975) report a prevalence of 7.2 per thousand of children who do not speak at school at the age of 5. Thus, some eight weeks after starting school, 42 out of 6072 children were not speaking, but after 12 months the rate had fallen to 0.33–0.66 per thousand. Thus, their rate of 'persistent elective mutism' is closely comparable to that reported in the Kolvin and Fundudis epidemiological survey. Brown and Lloyd's survey is complicated by ethnic factors and they used a rather broad definition of elective mutism. Nevertheless, it confirmed that persistent elective mutism is rare. Hayden (1980) reports on the results of a clinical study of 68 cases of elective mutism, based on a five-centre study in the U.S.A. However, the diagnostic criteria employed are questionable: they are rather broad and the duration of mutism was often very brief; there was inadequate specification of the settings in which the child refuses to speak, and there was diverse co-morbidity.

3.2. Diagnosis and Differential Diagnosis

A number of important themes merit consideration. First, previously there was both a tendency to emphasize the importance of mo-

tivation in the diagnosis of elective mutism and acceptance of the notion that the presence of abnormalities of speech and language precluded such a diagnosis. However, such earlier views were based on anecdotal material or small case studies without controls. As indicated above, studies of more representative series of cases indicate that such previous accounts were often misleading.

Second, in a pilot observational study of pre-school children, Kolvin/Nolan (1979) observed that unusual shyness occurred frequently, especially in girls, but this tended to be transient. The behavior consisted of a tendency to speak in a soft voice or an unwillingness to speak to their mothers or to play in the presence of strangers, combined with a tendency to cling and hide behind their mother's skirts. This reluctance to talk proved to be a transient phenomenon which is likely to reflect normal separation anxiety compounded by transient adaptation reactions to the usual stresses and unfamiliarity of the new school situations. Thus with familiarity, this anxiety diminishes and the child may begin to talk (Cantwell/Baker 1985). The latter authors suggest that many of the children in the Brown/Lloyd (1975) sample may have demonstrated this behavior.

Hence, it is not unexpected that confusion may arise with those excessively shy infant school children who do not speak when first attending school. However, shyness is not specific to elective mutism (Wilkins 1985). Hence Kolvin/Fundudis (1981) go on to suggest that a distinction needs to be made between such transient states of inordinate shyness and those behaviors which are pathological, in both severity and persistence. They therefore apply more rigorous criteria when defining elective mutism as persistent, severe and pathological shyness beyond the home situation, which is usually associated with abnormalities of temperament and of relationships of the child with his/her mother. If the mutism had been evident at the start of school life, then it had to show no signs of abating in the following year. If the mutism appeared to have a later onset, there had to be no evidence of diminution, again over a period of at least a year.

Third, there is little diagnostic difficulty with the early-onset (Kolvin/Ounsted/Humphrey et al. 1971) and the late-onset psychoses of childhood (Kolvin/Berney 1990; Kolvin et al. 1971), about which there is now considerable agreement.

Fourth, another crucial issue concerns the distinction between elective mutism and Asperger's syndrome (Asperger 1944). Although both groups of children have initial problems of social adjustment, which mainly declare themselves outside the home, there are many important differences. In both there is evidence of a lifelong personality deviation rather than an illness with a definite onset (Kolvin/Fundudis 1981; Wolff/Barlow 1979). Whereas the children with Asperger's syndrome are often described by their mothers as solitary, remote and strange, in the case of electively mute children the parents are often not aware of anything unusual until the children first attend school (Kolvin/Fundudis 1981). The children with Asperger's syndrome are described as showing obstinacy and aggressive outbursts, especially when attempts are made to persuade them to conform. However, the obstinacy of elective mutism is more usually combined with degrees of withdrawal or retreat. Next, while obsessionality is almost universal in Asperger's syndrome, it occurs only occasionally in elective mutism. By definition, none of the elective mutes speak outside the home or at school, whereas in the case of Asperger's syndrome only a few refuse to speak at school. Finally, whereas electively mute children use gestures and other forms of non-verbal communication, children with Asperger's syndrome tend not to communicate well by such means.

A further issue is the classification of children who speak rather little. We endorse, first, the view that those children who speak very little in all circumstances should not be assigned the diagnosis of elective mutism (Blake/Moss 1967), and second, the view that those children who display 'reluctant speech', i. e. they will not speak spontaneously but will answer questions which have been asked, should also be excluded from the specific diagnosis (Williamson/Sewell/Sanders/Haney 1977).

3.3 Developmental and Biological Factors

In most major studies of elective mutism there is a consistent pattern of an excess of girls to boys, which is unusual for childhood disorders (Kolvin/Fundudis 1981; Wilkins 1985; Wright 1968). In the investigation by Kolvin and Fundudis, the control group was drawn from a general population sample, whereas in Wilkins' research the elective mute sample was compared with a matched sample of clinic children who had been diagnosed as

having an emotional disorder. In both studies there was an excess of birth complications but this was significant only in the former study. However, Kolvin/Fundudis (1981) report evidence of slow or uneven development compared with the controls and this included delay in onset of speech, excessive developmental mispronunciation with associated problems of speech and bowel and bladder function, and also EEG immaturity. The case-note study by Wilkins provides an account of one in three of the electively mute children having delayed speech, whereas none of the children with emotional disorders had such problems. Although he does not report any other developmental anomalies, it should be remembered that in a case-note study there has not necessarily been a specific focus on particular deficits, and therefore a lack of listing does not necessarily imply absence of deficit. To recapitulate, Wright (1968) found that about one in five of his study children had an underlying speech or language delay or problem; Kolvin/Fundudis (1981) report as many as 50 percent and Wilkins (1985) reports 33 percent.

Kolvin/Fundudis (1981) report that electively mute children are born significantly early in the sibship but Wilkins (1985) did not replicate this finding. However, electively mute children in both studies come from families of similar size as those of the controls.

3.4. Personality and Temperament

In addition to inordinate shyness and social and communication problems, a diversity of other personality and temperamental anomalies have been described in these children (Kolvin/Fundudis 1981).

Evidence of an insidious development of shyness has been reported in over 80% of cases and even in those where it appeared acute, it may well be that the essential abnormality became dramatically obvious only when the child entered the school setting (Kolvin/Fundudis 1981; Wright 1968). In addition, a wide variety of complex personality patterns often occur, such as oppositional behavior and poor malleability both at school and at home. The commonest personality pattern was of sulkiness combined with aggressiveness, with a child presenting as sulky to strangers and aggressive within the home. Many of these children are described as having powerful personalities, with 'wills of steel'. About a quarter showed a combination of shyness in social situations with submissive-

ness at home. Another quarter seemed to be rather sensitive children. In addition, there was an important trend for such children to be more withdrawn in relation to peers than to adults.

In addition to the above personality patterns, there were a varied group of patterns of problem behaviors in over two-thirds of the children. These included excessive and unusual motor activity. Wilkins (1985) was not able to study personality and behavior systematically, and therefore merely listed those features which occurred more frequently in the elective mutes than in children with emotional disorders. His analysis appears to play down shyness and emphasize anxiety and depression as symptoms in the elective mute group, but he does report manipulative behavior. However, it must again be stressed that a retrospective case-note study from a psychiatric clinic may not be sufficiently focused on features under scrutiny and inevitably there may be distortions in the data.

3.5 Cognitive Aspects

Again, literature review reveals few studies quoting psychometric findings with even modest-sized samples of electively mute children (Kolvin/Fundudis 1981; Wright 1968). The evidence available shows that although electively mute children as a group cover most ranges of intellectual ability as measured on non-verbal IQ, there is a distinct shift to the left. Thus, while the majority fall within the normal range of intelligence, a substantial concentration of elective mutes is found within the dull — normal and lower categories of non-verbal intelligence (Kolvin/Fundudis 1981; Wright 1968). The reason for the poorer performance on nonverbal IQ remains obscure. Nevertheless, there are a number of other features among elective mute children which may have important associations with their poorer performance: first, as indicated above, electively mute children display a wide variety of complex temperamental, personality and behavioral patterns (Kolvin/Fundudis 1981) which may vary according to the circumstances in which the child is assessed; further, underpinning these various patterns of temperamental expression is a 'will of iron' and a determination to get his/her own way.

In general terms, when electively mute children do speak — which they do within the confines of their own homes — their vocab-

ulary, verbal conceptualisation of ideas and grammatical structure of sentences are usually normal.

3.6. Assessment

Enlisting co-operation of the electively mute child for the purpose of psychological/psychiatric assessment usually constitutes a challenge, the bases of which are the complex emotional and attitudinal expressions which accompany the refusal to talk. Thus, co-operation is best facilitated by the clinician adopting a style of communication which avoids expectation of the child to talk. In contrast, pressure by the clinician is likely to intensify the child's resistance, which is compounded by the excessive reserve/shyness and/or passive hostility which accompanies the child's refusal to talk. For younger children, drawing and play materials as a medium for preliminary interaction is often helpful. Subsequently, standardized non-verbal measures are the main source of assessment, particularly among the older children. The use of play materials and other purposeful tasks or activities can prove a helpful and meaningful way of not only engaging the child but also of obtaining a productive cognitive assessment. In those children with more highly resistant attitudes, the assessment may have to be carried out over a number of sessions with the tasks and measures being administered in a piecemeal fashion.

Skill, flexibility and patience are the guiding principles for achieving a useful and valid psychological/psychiatric assessment. They are also important for understanding the child's cognitive potential, personality, strengths and vulnerabilities and for establishing the basis of an individually tailored, multimodal, therapeutic programme.

3.7. Family and Social Factors

There is a tendency to assume that more of the families of electively mute children come from the lower end of the social class spectrum, but the evidence is that the families of these children are represented at all levels of socio-economic strata (Brown/Lloyd 1975; Kolvin/Fundudis 1981; Wright 1968). Of greater importance is the nature of the psychological dynamics within these families. The literature abounds with examples of parents with unusual personalities and psychiatric problems which are often offered as explanations for the elective mutism of their children (Elson/Pearson/Jones/Schumacher

1965; Parker/Olsen/Throckmorton 1960; Wergeland 1979). The confidence placed in these findings must be limited by the lack of controls and small sample size of the studies upon which the theories are based. Some of the factors which have been viewed as causative include the following: maternal rejection and paternal disinterest (Elson et al. 1965), maternal anxiety, fearfulness and overprotectiveness (Parker et al. 1960; Wergeland 1979), the influence of 'family secrets' and the child's fear of parental retaliation (Pustrom/Speers 1964), abusive behavior by alcoholic fathers (Adams/Glasner 1954), and the effects of a symbiotic relationship between parent and child (Browne/Wilson/Leybourne 1963). However, most of these notions derive from older publications.

Evidence from a controlled and larger study of 24 cases (Kolvin/Fundudis 1981) does not suggest the presence of a common set of family dynamics, but rather the origins appear multifactorial. In that study, one-third of the parents of electively mute children were found to have personalities that were characterized by serious or marked reserve and shyness. Taking into account all of the personality problems of the parents, irrespective of type, in two in five of the families one or other of the parents had a personality which could best be described as odd or unusual. As to psychiatric problems, severe neurotic disorder was found in one of the parents in about one-sixth of the families and depression in one of the parents, again in one-sixth, with a combination of these two disorders occurring in a number of the families. When serious psychiatric disturbance or major personality problems were considered in combination with serious marital disharmony it was found that six of ten of the families were affected. Thus, however, the disturbance in families is defined, the available evidence points to an excess of psychological morbidity in families of elective mute children compared with families of normal control children (Kolvin/Fundudis 1981). For instance, these authors noted that 20% of mothers and 16% of fathers of elective mute children had received specialist psychiatric help, compared with only 8% of mothers and 3% of fathers of normal control children.

In a study of 24 families, Wright (1968) reported a 75% rate of parental psychological disturbance. This higher rate was probably due to the inclusion of the use of a much broader definition of disturbance, for instance

including the trait of parental shyness as one of the criteria. Further, as shyness in parents of electively mute children appears to be fairly common (Brown/Lloyd 1975; Kolvin/Fundudis 1981; Wright 1968), it raises the interesting possibility of a familial or even a genetic link between shyness of the parents and elective mutism of the child. The latter possibility is enhanced by the finding of a number of affected siblings (Wright 1968) or twins (Halpern/Hammond/Cohen 1971; Mora/DeVault/Schopler 1962) in different series of electively mute children. On the other hand, the influence of learning/modelling cannot be discounted.

3.8. The Aetiology of Elective Mutism

As evident above, numerous workers have postulated a diversity of psychogenic bases for elective mutism; others imply that it is a learnt pattern of behavior, and yet others implicate temperamental or personality factors which have a familial basis. Another suggestion is that it may be a secondary psychological reaction to some biologically based symptoms; for instance, some children may avoid speaking because they are teased when they mis-pronounce words (Rutter 1977); other work suggests an important maturational component. This diversity of aetiological factors suggests that the origins are multiple and the condition heterogeneous.

3.9. Intervention and Outcome

Elective mutism has been, and continues to be, a challenge to psychodynamically and behaviorally oriented psychotherapists. The reported success rates of the different methods of intervention have been variable; however, it is difficult to draw any conclusions from such studies because of the differences in diagnostic criteria used, the severity of the mutism and the criteria of improvement. For example, Wright (1968) reported that at follow-up of 19 of 24 cases, 79% had achieved 'excellent' or 'good' adjustment, whereas Kolvin/Fundudis (1981) report an adjustment rate of 46%. Further, the confidence in success rates reported in other studies is limited by small samples and poor specification of improvement criteria (e. g. Elson/Pearson/Jones/Schumacher 1965; Kupietz/Schwartz 1982; Pustrom/Speers 1964). For example Elson et al. (1965) noted that most of the children "tended to have made a fairly good adjustment" following their discharge from hospital, but that there was a "tendency to be

somewhat reserved" (Elson et al. 1965, 185). The problem of defining treatment success or improvement has been further highlighted by Pustrom/Speers (1964) who report that, in three cases, after intervention some improvement was achieved in terms of readiness to talk to others, but they resisted talking to the therapist. The authors concluded that "failure to speak to his therapist represents a last-ditch stand against giving up his omnipotent control over others" (Pustrom/Speers 1964, 296). Such statements emphasize the intractability of elective mutism to psychotherapy, in that although degrees of improvement are usually reported, the spontaneity of interpersonal communication of the electively mute child is seldom fully shifted.

The emphasis of earlier treatment approaches on intrapsychic dynamics (e. g. motives, drives, personality traits) of the electively mute child and/or the parents (e. g. Browne/Wilson/Legbourne 1963; Chetnik 1973; Elson et al. 1965); have tended to give way to the more recently developed behavioral strategies (e. g. Kupietz/Schwartz 1982; Nolan/Pence 1970; Norman/Broman 1970). Such a shift is not surprising because the resistance of elective mutism to treatment has continued to pose a challenge to therapists of all persuasions. However, some reviewers conclude that behavioral therapies have been found to have greater effectiveness than the psychodynamic therapies (Kratochwill/Brody/Piersel 1979). In keeping with the more pragmatic stance of the behaviorists it has been argued that intervention should be directed not only at 'mutism' but more broadly at 'social skills' (Kratochwill/Brody/Piersel 1979). Consistent with the above is the proposal of a multidimensional management approach (Friedman/Karagan 1973) consisting of the following: a) avoidance of strategies that are likely to put pressure on the child to talk; b) inclusion of the child in small peer group activities; c) use of reading, story-telling and other verbal activities which do not make the child feel especially uncomfortable (e. g. within the family context); d) encouragement by parents for relatives and peers to visit within the electively mute child's home to create a natural social context of conversation but without putting pressure on the child to talk; e) encouragement within the classroom situation for the electively mute child to engage in non-verbal, non-threatening interpersonal relationship through the use of such activities as puzzles and workbook

exercises; f) a gradual process of encouragement involving the electively mute child in a one-to-one situation where appropriate stimuli (e. g. pictures which require to be identified and labelled, e. g. *what is this?*) are used as a means of creating a spontaneous form of verbal communication on the part of the electively mute child, and then including one or two other children in the activity; g) the electively mute child and any others in whose presence the child is prepared to talk are encouraged to engage in activities outside the home. This broadbased behavioral approach seems attractive but it merits more careful evaluation.

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