

Elective mutism: A case study

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We report a case of persistent elective mutism in a young single woman. To our knowledge there has been no published study or case report of persistent elective mutism starting at the age of acquisition of language and persisting until she was 22. (Int J Psych Clin Pract 2002; 6: 49–51)

Keywords

elective mutism
social anxiety

pathological shyness
aphasia voluntaria

INTRODUCTION

The German physician Kussmaul was the first to describe elective mutism. In 1877, he reported three clinical cases and termed the condition “aphasia voluntaria”.¹ The first person to use the term “elective mutism” was Moritz Tramer, a Swiss child psychiatrist, in 1934.¹ Elective mutism is defined in ICD10² as “marked emotionally determined lack of speech in certain situations in a child with normal, or near normal, speech/language ability”.

CASE REPORT

Miss X is a 24-year old, single, unemployed woman, living with her mother and two younger sisters. Starting from around the time she commenced school, it was noticed that she had great difficulty in communicating with anyone outside the home, and for many years she conversed only with her mother, and this continued until she was 22 years old. When she was three her mother noticed that she was a shy, inhibited child and showed a degree of emotional coldness to her newborn sister. Because of her problems at this time, she was sent to play school, which it was hoped would improve her social and communication skills. But she failed to speak to anyone while she was there, although she was able to interact and make friends.

When she was at primary school, her teachers asked her mother to obtain tape recordings of her conversations at home, as they were concerned that she did not talk at all. The tapes obtained indicated that her verbal language skills were normal for her age. She was allowed to remain in mainstream school and took her GCSE exams at the normal age of 16 years, achieving five subjects at D and E

grades, failing only in German language and music, due to the oral component of these exams. Following on from school she applied for college courses but was refused admission, as she was not able to speak at interview. However she enrolled on, and successfully completed, a 6-month computer course. Later on she managed to get a place at technical college. Her current situation is that she is attending college, has friends, and no longer refuses to speak in some situations.

She has not got along with her middle sister since childhood; however she got on reasonably well with her youngest sister for a time when they were younger, and used to play and communicate with her, until 6 years ago, when her father died of a heart attack, after which she became more dependent on her mother and talked to her mother only, until 2 years ago.

She presents as a quiet, inhibited, well-groomed lady who makes no eye contact. She exhibited features of social anxiety and some obsessional features. She spends much time in the bathroom getting ready and is very selective about the clothes she wears. She described herself as being a perfectionist, and is preoccupied with details. The criteria for obsessive compulsive disorder are not fulfilled: she denied a feeling of subjective compulsion, or unpleasant irrational repetitive irresistible ideas, thoughts or images that she regards as alien. Nor did she meet the criterion of social phobia, as she denied irrational fear of, and compelling desire to avoid, social situations. Though she felt anxious, nervous, uncomfortable around strangers, she denied any experience of blushing, trembling or vomiting in social situations. The impairment in social, academic or family functioning was attributable directly to her refusal to speak, and one concludes that she has marked social anxiety but not social phobia.

She was diagnosed as suffering from elective mutism (ICD-10). Her first contact with psychiatric services was with the Child Clinical Psychology Services when she was in primary school. At this time she was treated with a gradual behaviour-shaping programme, initially including home visits from her teacher. She showed some response to it. In her early primary school years she did speak a little but apparently stopped again when she moved to the junior school, and thereafter refused any psychological or other form of treatment.

At the age of 18 (when following the death of her father, she would communicate only with her mother) she was again referred to psychiatric services.

Results of clinical investigations, including EEG, are within normal limits. Psychological tests included the Millon Clinical Multiaxial Inventory^{3,4} in its newest version; it is a well-researched self-report measure which has been updated explicitly to correspond to DSM-IV criteria for Axis I symptomatology and Axis II personality difficulties.⁵ The inventory has 24 scales: 11 Clinical Personality Patterns, three Severe Personality Pathology, seven Clinical Syndrome and three Severe Syndrome Scales; plus four Modifying Indices: Disclosure, Desirability, Debasement, and Validity, to ascertain test-taking attitude and validity.

Miss X's profile on this measure was valid. The predominant feature identified on the Clinical Syndrome Scale (corresponding to Axis I symptomatology) was anxiety. The most prominent features on the Clinical Personality Pattern Scales (corresponding to Axis II symptomatology) were Avoidant, Dependent, and Schizoid. However, her scores on these scales were not high enough to warrant diagnosis of a personality disorder. Her intellectual ability was not formally assessed, as her level of scholastic attainment, in spite of her elective mutism, clearly indicated that she was of at least average ability.

She was initially treated in day hospital and was advised to take part in music therapy, but this had to be discontinued, as she did not involve herself in the activities. In addition to this, on the basis of case reports,⁶ open and double blind controlled trial,^{7,8} it was decided to try various medications in her management. We tried phenelzine, as well as serotonin re-uptake inhibitors. She could not tolerate phenelzine or fluoxetine. She was started on 20 mg paroxetine a day, and her social anxiety reduced within a few weeks and she was able to answer the telephone at home; the improvement was more marked after 8 weeks. She obtained a place at technical college within 3 months and started speaking outside the home within a year. There were no adverse effects reported with paroxetine. She was also able to do voluntary work, has established relationships, and was discharged from the outpatient clinic. Although the role of non specific factors cannot be ruled out, all these improvements correlated with the introduction of paroxetine. Our finding is supported by recent research reporting that paroxetine is effective in social anxiety and social phobia.⁹

DISCUSSION

Transient elective mutism is not uncommon, but persistent elective mutism is a rare disorder.¹⁰ Until recently most of the literature on elective mutism has been single case reports or a series of case reports. There have been only a few epidemiological studies. In a survey conducted in all primary schools in Birmingham, the prevalence was reported as 7.2 per 1000 after 8 weeks of school, but after 12 months this figure had fallen to between 0.3 and 0.6 per 1000.¹¹

In another study carried out in Newcastle,¹² a longitudinal investigation of speech-retarded children, the prevalence of the condition was reported as 0.8 per 1000. Another study found only four cases among more than 2000 children referred to the Department of Psychiatry at the University of Manchester.¹³

The social contexts in which children do not speak are mostly situations in which they are expected to speak to strangers, e.g. at school. Miss X had such problems at school and later at college. In keeping with reports of certain patterns of behaviour in other studies (where verbal communication with one or other family member was non-existent), Miss X did not speak to her younger sister, although it has been most often reported that fathers are the group who were not spoken to.¹⁴

Associations between elective mutism and social anxiety have been reported.^{14,15} It has been suggested that elective mutism might be a symptom of social anxiety, rather than a distinct diagnostic syndrome.⁶ The severity of anxiety and social anxiety correlate with the severity of mutism. Our patient has shown features of social anxiety throughout her childhood and adulthood.

In personality profiles, shyness and internalizing behaviour have been reported as the most prominent personality features.¹ Shyness was reported as a prominent personality feature in 85% of children with elective mutism.¹ Miss X was a shy girl from the very beginning, even before the features of mutism appeared, and this may be complicated by schizoid traits.

The most striking feature of this case is the protracted course of her illness, which has lasted for about 20 years without any periods of full remission. One study found the illness to be persistent in only 54% of subjects, whereas it decreased with time in 35%, and another 8% showed a more fluctuating course of the symptoms.¹ Black and Uhde¹⁴ reported that the course of the illness could be persistent in a minority of children. One possible explanation might be pathological shyness,⁴ which in our case seems to have been complicated by schizoid and avoidant personality traits.

The mainstay of treatment until recently has been psychotherapeutic intervention, using various methods ranging from traditional psychoanalysis to behaviour modification techniques. An association has been reported between elective mutism and social anxiety,^{1,15} and this has opened the channels for pharmacotherapy. Phenelzine was

the first agent found effective, in a 7-year-old girl with a 2-year history of elective mutism.⁶ The first double-blind placebo-controlled study reported the efficacy of fluoxetine in such cases.⁷ Other studies have also shown the efficacy of fluoxetine in diminishing anxiety and increasing speech in a public setting.⁸ Miss X has shown improvement on paroxetine (20 mg), which she was given because she could not tolerate fluoxetine: her communication at home, as well as in social situations outside the home, has improved and her social anxiety has decreased. The efficacy of paroxetine in social anxiety and social phobia has also been reported in a randomized, double-blind, placebo-controlled study.⁹ She improved sufficiently to be discharged from the outpatient clinic.

KEY POINTS

- Elective mutism may simply represent the most severe end of the spectrum of childhood speech inhibition and social anxiety
- Transient mutism is not uncommon but persistent elective mutism is rare
- It can affect academic, social, or family functioning considerably
- Evidence suggests that SSRI drugs can be effective in elective mutism.

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